Canadian Hospital

- *Presidential Address*
- *Accreditation Service*
- *Twelfth Biennial Meeting*
- *Modernizing Dietetic Facilities*

June, 1953

Official Journal—Canadian Hospital Council

we, too, are proud—

of Peterborough Civic Hospital's New Laundry

The people of Peterborough, Ontario, have reason to be very proud of their new 240-bed Civic Hospital. Replacing the former hospital which served the community so well, the new hospital is truly a tribute to the benevolent spirit of the citizens of Peterborough and the city's profound interest in public welfare.

Aware of the importance of a plentiful supply of sterile-clean linens for the treatment and care of patients, the authorities of Peterborough Civic Hospital called in our Laundry Advisor when planning erection of the new hospital. He made a thorough analysis of the clean linen requirements and linen control system for the new hospital. Then, working with the architect, he recommended equipment and submitted a detailed floor plan layout for a new, modern laundry department.

Now, with the new laundry in operation and performing in an excellent manner, our Company takes great pride in having been privileged to participate in this splendid project.

Whether you are planning a new hospital laundry, or your present laundry department is inadequate and in need of modernization, the services of our Laundry Advisor are offered to hospitals, large or small, without any cost or obligation whatever. Our Laundry Advisor will gladly work with you to make your laundry department one of which your hospital, and our Company, too, will be very proud. WRITE TODAY, and our Laundry Advisor will call at your convenience.

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LAUNDRY MACHINERY CO., LIMITED
47-93 STERLING ROAD, TORONTO 3, ONT.

WESTERN REPRESENTATIVES—Stanley Brock Limited, Winnipeg, Calgary, Edmonton, Vancouver.

● **Partial view of Laundry at New Peterborough Civic Hospital, showing two CASCADE Washers and two ZONE-AIR Drying Tumblers (at right), MONEX O.T. and Solid Curb Extractors at left. Complete equipment furnished by The Canadian Laundry Machinery Co., Limited, also includes a 6-Roll STREAMLINE Flatwork Ironer and two Press Units for ironing nurses' uniforms and other hospital apparel.**

Contents

Vol. 30 **June, 1953** No. 6

(For Subscription Rates, see page 112)

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OFFER ALL THE ADVANTAGES OF TRAVERT*

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REPLACEMENT OF ELECTROLYTES, AND CORRECTION OF ACIDOSIS AND ALKALOSIS

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Less frequent linen changes—more time for more important duties.

SAVES BED-LINEN and Laundry Burden

Sheets last longer with fewer changes—reduces laundry costs.

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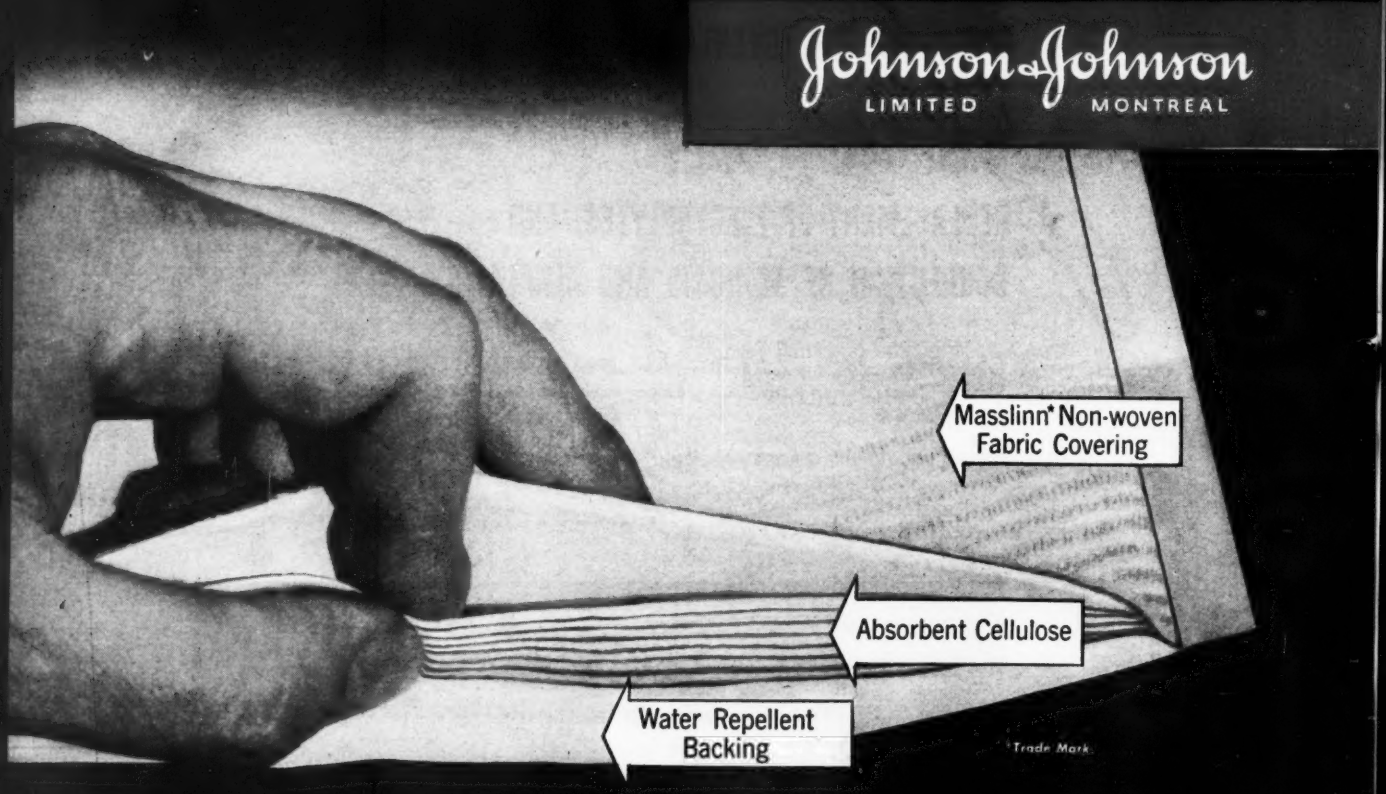

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The Federation of Hospital Associations in Canada and the Canadian Medical Association, in co-operation with the Federal and Provincial Governments and voluntary non-profit organizations in the health field.

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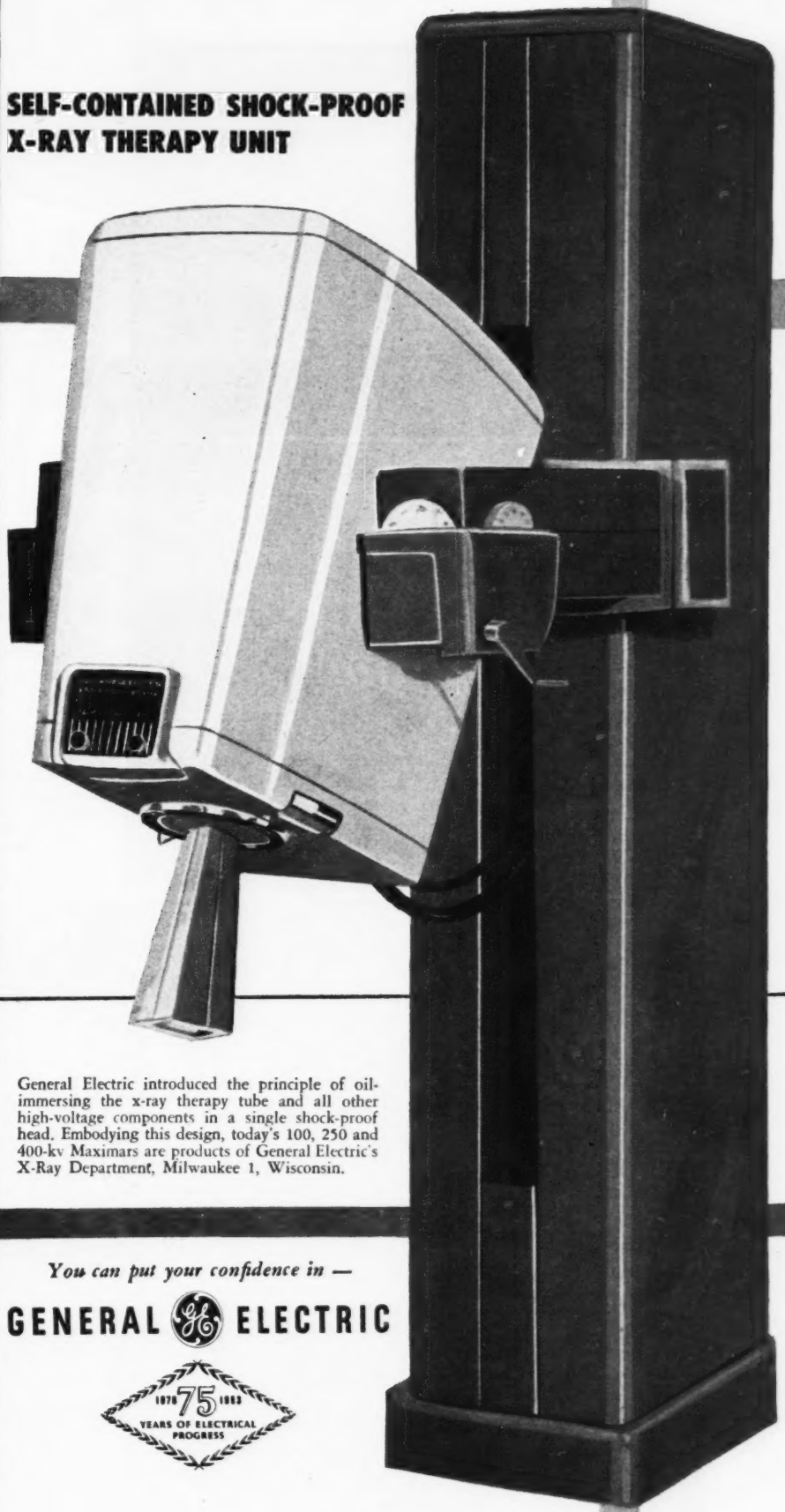
FIRST

SELF-CONTAINED SHOCK-PROOF X-RAY THERAPY UNIT



General Electric introduced the principle of oil-immersing the x-ray therapy tube and all other high-voltage components in a single shock-proof head. Embodying this design, today's 100, 250 and 400-kv Maximars are products of General Electric's X-Ray Department, Milwaukee 1, Wisconsin.

You can put your confidence in —

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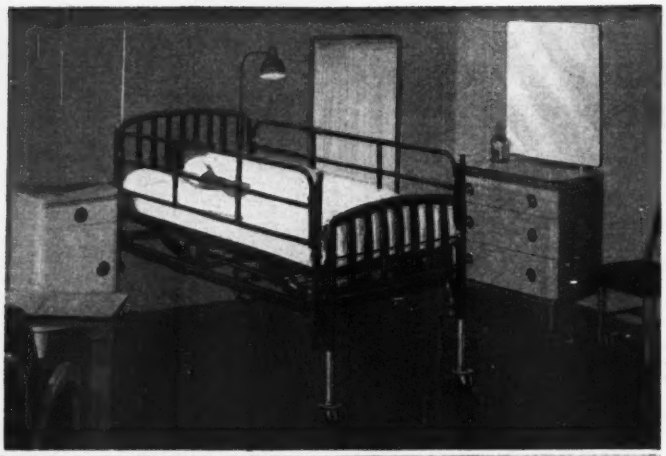


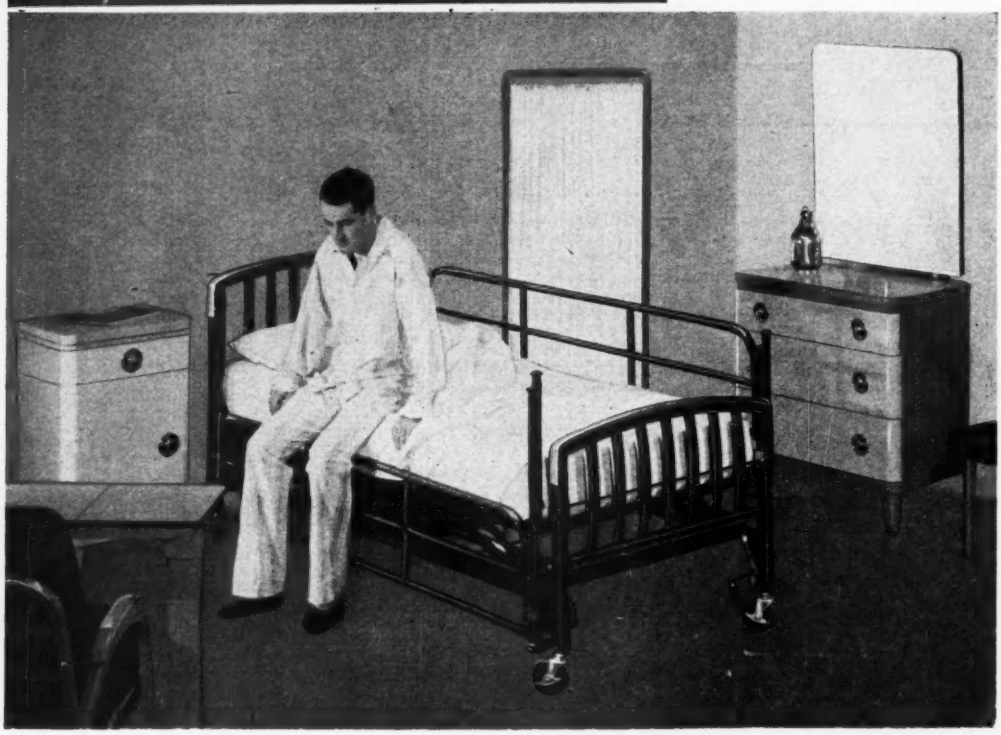
Vari-Hite in the raised position with both sides up eliminates dangers from falls. Note special bracket for holding crank when not in use is easily accessible but out of sight.

"Up position"

Spring is raised to 28" from the floor — the bedside can be lowered (as illustration) and does not have to be removed.

"Down position"

Vari-Hite in the lowered position ends patients' fear of being at an unfamiliar height. —It can be easily raised from either end or either side to hospital level for treatments.



Notes on Federal Grants

Construction

A new hospital will be built at Sweetsburg, P.Q., to replace a smaller hospital. The new building will have 89 beds; 21-bassinet nursery; surgical and x-ray departments; and a community health centre. The federal grant towards the cost of construction will be $104,000.

A grant of $8,000 has just been made to the Hanna Municipal Hospital, Hanna, Alta., to assist with the cost of enlarging its accommodation. Space formerly occupied by nurses on the hospital's ground floor is to be converted into accommodation for eight additional patients, thus bringing the hospital's total bed capacity to 43. The Hanna hospital serves about 6,500 people in the 59 townships of hospital district No. 9.

Hospitals in Trail, Penticton, and Squamish, B.C., have just been awarded federal grants totalling $162,600 to help meet construction costs. In Trail, a new hospital is being built which will provide space for 162 beds, nurseries for 42 infants, and modern medical, surgical and obstetrical facilities. The federal grant is $73,000. The new hospital, built in Penticton, approximately doubles the capacity of the old hospital. It has space for 132 beds and a 32-bassinet nursery. A large dwelling adjacent to the hospital will also be converted into a nurses' residence. The federal grant for these projects is $86,100. At Squamish, the Squamish General Hospital has been allotted approximately $3,500 towards the cost of providing accommodation for eight nurses.

At Eston, Sask., a new hospital is to be built to replace one destroyed by fire last December. To serve about 3,500 people in the town and surrounding district, it will have 25 beds, a six-bassinet nursery; medical, obstetrical, x-ray, and laboratory facilities; and a community health centre. The federal and provincial governments are each contributing $24,000 toward the building costs.

A federal grant of $6,000 has been earmarked for the Assiniboia Union Hospital, Assiniboia, Sask., where alterations are to be made this year to increase the hospital's bed capacity by six.

Hospitals in Moncton, Fredericton, and Woodstock, N.B., have been awarded federal grants totalling $238,900 to help them meet their building costs. At the Hôtel Dieu de l'Assomption, Moncton, a new wing is being added to the present hospital. Scheduled for completion next year, it will have space for 88 more patients, nurseries for 29 infants, an out-patient department, and accommodation for 13 nurses. It will include a laboratory and pharmacy, and x-ray facilities will be extended. The grant will be more than $120,900. Extensions of the north and east wings of the Victoria Public Hospital, Fredericton, will provide space for 37 additional patients and for increased x-ray and operating room facilities, as well as other ancillary services. Construction is scheduled for completion in about a year. In Woodstock, a new hospital, the Carleton Memorial, is to be built to replace the present obsolete hospital. When construction is completed late next year, it will have space for 75 patients, nurseries for 21 infants, and modern medical, surgical, and obstetrical facilities. The federal grant to the Fredericton hospital has been set at $37,000 and to the Woodstock Hospital, $81,000.

The new St. Elizabeth's Hospital at Humboldt, Sask., will have space for 76 beds, nurseries for 23 infants, and all related facilities. A federal grant of more than $83,600 will help toward building costs. At Shaunavon, Sask., the present hospital is to be enlarged this year to accommodate 14 additional patients and 10 infants. The federal grant is more than $17,300.

The Wolseley Memorial Union Hospital, Wolsely, Sask., is to be enlarged to provide space for 10 additional beds and a community health centre. The federal government is matching a provincial grant of $10,000 toward the cost of this work. In Kelvington and Unity, Sask., the hospitals are receiving $9,000 toward the cost of providing nurses' residences. The Kelvington Union Hospital has been granted $4,000 and the Unity Union Hospital will receive $5,000. At Rocanville, Sask., a new community health centre has been allotted $3,000 from both the federal and from the provincial government

Professional Training

A federal public health bursary for training as an electroencephalograph technician has been awarded to a resident of St. Peters, P.E.I. He will take a year's training in various Nova Scotia hospitals where the electroencephalograph is used and on his return will join the staff of the Falconwood Hospital, Falconwood, P.E.I. The bursary is valued at more than $2,200.

Four bursaries for advanced training in various aspects of public health have been awarded to Alberta residents. A nurse on the staff of the Calgary General Hospital is taking four months' training in neurological nursing at the Montreal Neurological Institute. An Edmonton doctor will spend three months with Atomic Energy of Canada Ltd., Chalk River, Ont., learning techniques for the use of radioactive isotopes in biological research. A member of the staff of the Royal Alexandra Hospital, Edmonton, will spend a month studying the administration and management of an obstetrical department at the New York Hospital, New York City, N.Y.; and a science instructress at the University of Alberta School of Nursing will attend a short course to be given at McMaster University, Hamilton, Ont. The bursaries are valued at about $2,300.

Public Health

The Cerebral Palsy Association of British Columbia has been allotted a federal grant of $7,000 to help carry out its services this year. The association now has about 50 children under its care. Approximately 35 children receive intensive treatment either daily or at stated intervals during the week. In addition, about 15 children living throughout the province come to Vancouver periodically for check-ups and evaluation of home-treatment programs.

The federal grant provides salaries for a medical social worker and a speech therapist. The social worker is

(Continued on page 16)

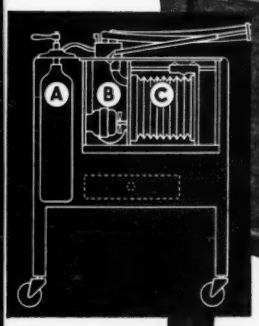
....we consider

the Patient's

viewpoint

.... with the Sanborn

METABULATOR



All moving parts are completely concealed during a test.

When Metabulator patients approach their testing experience they see the instrument as an attractive, non-mechanical and *non-medical* looking mahogany cabinet-set. And, during the test, it is not possible for their view to include such curiosity-arousing components as the oxygen tank ("A" in drawing above), the motor-blower ("B"), the rubber bellows ("C"), or the writing unit—all are *out of sight, out of mind!*

One-level operating control permits a more casual testing manner

—which, in turn, conduces to increased patient relaxation.

While the patient sees nothing during a test the operator *casually* takes in everything *at a glance*—the close grouping of oxygen tank valve handle, breathing valve, barometer and thermometer dials, and the chart recording compartment.

This *exclusive* design idea ends much of the nervous apprehension that the BMR patient is often prone to.

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Keleket X-Ray Corp. **Sanborn Diagnostic Equipment**

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latest clinical report[1] demonstrates D & G Aureomycin Packing is "far superior"

Recent investigators state: "Aureomycin Packing is far superior to iodoform gauze, plain gauze or any other type of gauze packing known to us."[1] The study covered many different types of abscess, as well as postoperative and non-postoperative wound infections, from all of which 12 strains of bacteria were isolated. Untreated sterile packing and iodoform packing were used as controls.

High, prolonged antibacterial action: After 16 hours, 65.4% of the aureomycin had been utilized, and after 48 hours, 93.3%. Thus D & G Aureomycin Packing helps heal infected wounds *otherwise inaccessible to systemic antibiotics* because of the presence of an inflammatory wall with thrombosed blood vessels and a total decrease in blood flow.

No interference with wound healing: "Aureomycin and plain packing showed no impairment of growth of cells in tissue culture. . . . Iodoform showed decreased growth."[1]

Relatively non-toxic: "No significant local or systemic toxic effects were noted, nor was allergy or local skin irritation in evidence."[1] Also, "Foul odor . . . was considerably reduced."[1]

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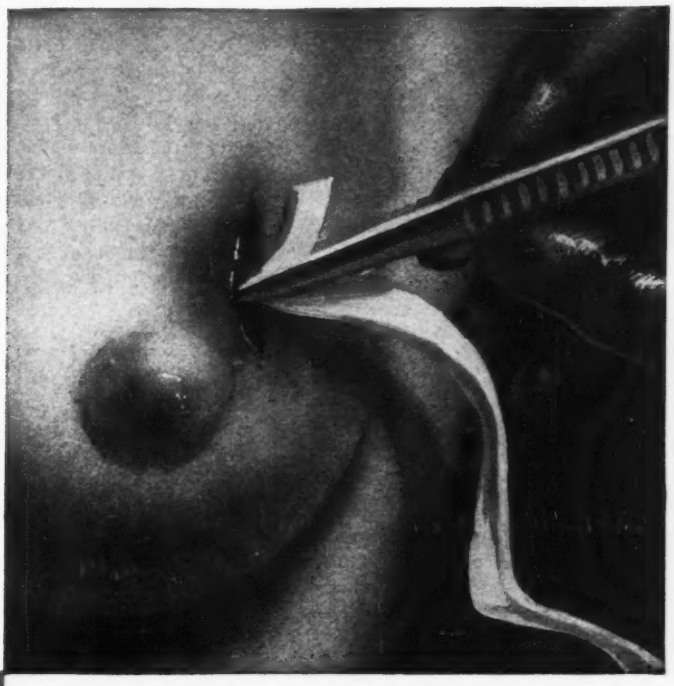
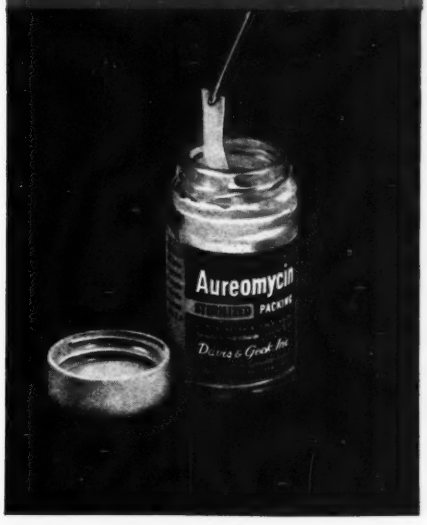
57 Willoughby Street — Brooklyn 1, N. Y.

1. Marchisello, P. J., Prigot, Aaron, and Wright, L. T.: Am. Jour. Surg., Dec., 1952





Aureomycin Dressing

◀ *D & G Aureomycin Dressing*
helps hasten healing by controlling infection on skin graft sites, wounds, burns, rectal sites, etc. It is a close mesh 8″ x 12″ gauze liberally impregnated with a non-adherent base containing 2% aureomycin hydrochloride.

◀ *D & G Aureomycin Packing*
is a non-ravel, double-selvage sterile gauze impregnated with crystalline aureomycin hydrochloride. Available in ½″, 1″ and 2″ widths.

Request Aureomycin Packing and Aureomycin Dressing from the Surgical Supply Dealer who supplies your Davis & Geck sutures. Ask your nurse to keep these potent aureomycin aids in your treatment room. Your O.R. Supervisor has them now.

▶ Now available—new film "Aureomycin to Combat Local Infection"—send requests to D & G Film Library

Federal Grants

(Continued from page 12)

responsible for arranging for children to be tested by a panel of medical specialists before being admitted for treatment and for liaison with parents to ensure that they play their proper part in the home-treatment phase of care. It is hoped to add a full-time speech therapist to the association's staff, this year.

Grants to aid treatment services for poliomyelitis patients and other crippled children at the Victoria General Hospital, Halifax, N.S., and for an expanded health education program in the city of Halifax have been approved by the federal health department. Some months ago, all physiotherapy services at the Victoria General Hospital were re-organized to bring them into a single department headed by a trained physiotherapist. As about half his time is devoted to the care of children at the Polio Clinic, federal aid has been approved to cover the cost of this service. The Halifax City Health Department will receive a grant to purchase equipment needed to expand its health education program. Total value of the grants is more than $2,300.

Federal funds have been set aside to help set up a public health library in Saskatoon, Sask. The library will be used by students in the new public health nursing course at the University of Saskatchewan and its books will also be available on loan to medical and public health personnel in all parts of the province.

Research

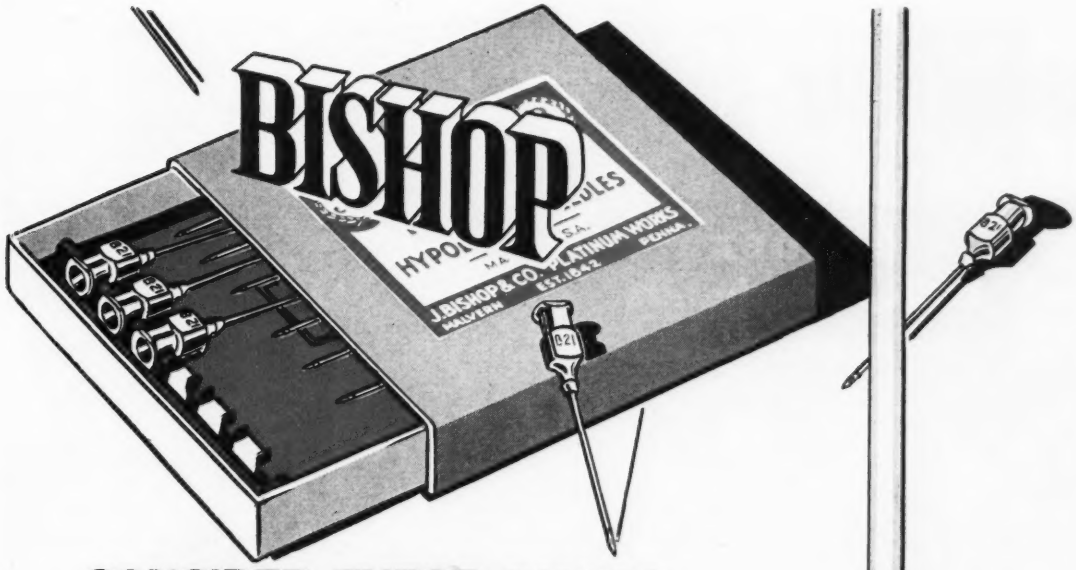
A disease common in rural areas, suppurative ringworm contracted from cattle, is to be investigated by scientists at the University of Manitoba, Winnipeg. They hope to discover new facts about the origin of this disease and thus to improve treatment procedures and perhaps to devise means of controlling its spread. The research includes collection of test materials from patients for microscopic and cultural studies to determine the fungi causing the disease, as well as studies of barn dust and soil from the patient's farm to see if the reservoir of infection can be discovered and control measures instituted. Studies will be undertaken to ascertain whether or not treatment with the new antibiotics is effective.

The study, which will last for one to two years, will be carried out at the Winnipeg General Hospital, the Children's Hospital, Winnipeg, and with the co-operation of general practitioners in rural Manitoba. The federal grant to cover the cost of the research is $1,900 in the current fiscal year.

A research program designed to find improved ways of treating and preventing narcotic addiction is to be undertaken in British Columbia with the support of federal funds. The study arises from a recommendation by the Community Chest and Council of Greater Vancouver and will be carried out under the direction of a committee of scientists from the University of British Columbia.

The plans involve organization of a research team to conduct a battery of interviews, tests, and examinations. These will be set up to determine the principal personal and physiological characteristics of a group of addicts

(Concluded on page 20)



CONSIDER THESE POINTS WHENEVER YOU BUY *Hypodermic* NEEDLES

A fine quality needle safeguards your patients against deep infection, often caused by burrs of metal, chips and abrasives left on ordinary needles. Bishop "Blue Label" Needles provide **maximum safety** because . . .

1 **Tougher Steel Resists Breakage.** 18-8 stainless steel is inherently tough. Bishop intensifies this quality by exacting metallurgical control and special manufacturing processes. Furthermore, the corrosion-resisting properties of 18-8 stainless steel are not merely skin deep, but are inherent throughout its cross-section.

2 **The Point Design is More Efficient.** The special Bishop Rapier Point is sharp for quick, easy penetration with minimum discomfort. It spreads the tissues instead of slicing. There is less cutting, less pain, less seepage. And because less metal is honed off, the point is stronger.

3 **The Precision Hub is Chrome-Plated**—and conforms to government specifications. Here, Bishop precision manufacturing experience helps again. Because the taper is accurately machined, Bishop Luer needles fit syringe tips closer, minimize syringe tip breakage and leakage.

4 **Continuous Inspection Insures Cleanliness.** To insure uniformity, cleanliness and finish, expert inspections, including hydrostatic pressure and microscopic tests are made at ten vital stages of manufacturing, thus eliminating any possibility of infection through burrs, chips and abrasives.

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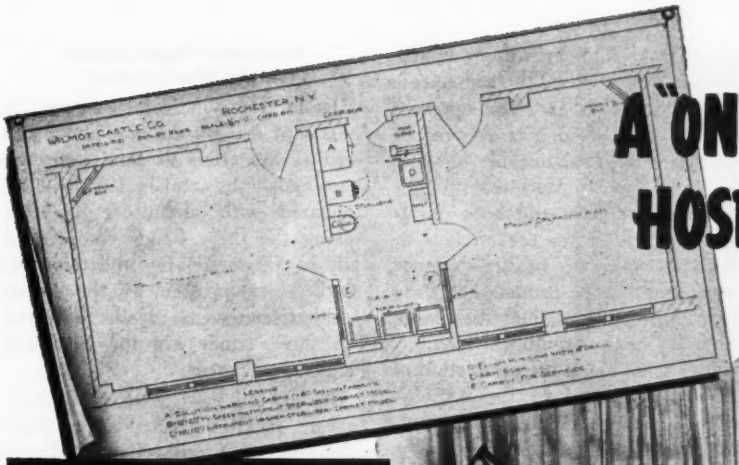
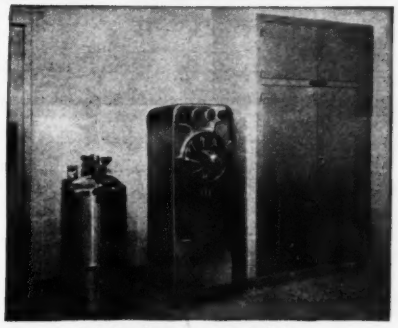
. . . with many Castle assists



Canada's newly completed KITCHENER-WATERLOO 347 bed hospital, widely publicized as the last word in modern construction, facilities and appointments, selected Castle Sterilizers and Surgical Lights . . . further acknowledgment of Castle's established leadership.



Sub-Sterilizer Room Installation.

Central Sterile Supply, with sterilizers cycled by Thermatic governors with remote control supervision.

***An innovation in having sub-sterilizing and scrub-up facilities in one room*—as recommended by Castle, is a featured facility most favorably commented upon.**

● Direct passage between corridor and sterilizers eliminates unauthorized traffic through operating rooms.

● Scrub-up sinks are placed on outer wall; sterilizers on inner wall nearest to nurse traffic. This saves nurses many minutes and steps in every operation. Surgeon's scrub-up is undisturbed, yet he may observe preoperative preparation of patient through transparent panel.

● *Only 3 sterilizing units required!*—Castle Hi-Speed Emergency Sterilizer . . . Castle Pressure Instrument Washer-Sterilizer . . . Castle Solution and Blanket Warmer. All dressings, utensils and flasked solutions and distilled water supplied by Central Sterile Supply.

● ARCHITECTS: Govan, Ferguson, Lindsay, Kaminker, Maw, Langley, Keenleyside—Toronto.

**The Canadian Hospital, Vol. 28, No. 7, p. 79, July, 1951.*

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Castle STERILIZERS AND LIGHTS

Federal Grants

(Concluded from page 16)

now in Oakalla jail and to assess the effect of economic and sociological conditions and family environment in causing addiction. A suitable group of non-addicts will also be surveyed in the same way to provide a contrasting or "control" group. Special emphasis will be placed on the study of young persons who have recently become addicts.

The data gathered from the two groups of addicts and non-addicts will be analyzed and interpreted in an effort to find methods of treatment. A careful study of the underlying factors which led to addiction will serve as a guide for preventive measures of various kinds. The federal grant this year will be $13,500, most of which will be used for salaries of a clinical psychologist and two psychiatric social workers, who will give full time to the study.

Improved methods of producing a growth-producing hormone made from pituitary glands of cattle are being worked out this year at the Connaught Medical Research Laboratories in Toronto, Ont. This growth-producing hormone, known as STH (somatotrophic hormone) has an effect opposite to that of ACTH and it is also recognized as having a relationship to some types of diabetes. However, its full effects are not clear and both physiologists and clinicians are anxious to explore its value to medical science as soon as it can be produced in pure enough form and in quantities large enough for adequate clinical tests.

Initial research on the production of STH was sponsored by the National Research Council. Work in the current year is jointly financed by the National Research Council, the National Cancer Institute of Canada, the Defence Research Board, the federal health department, and the Connaught Laboratories. Total cost is estimated at more than $22,400; the federal health department's share is over $13,000. The research is under the direction of Dr. R. D. Defries, director of the Connaught Laboratories.

A soulful look is not necessarily a sign of yearning for the infinite. It may be merely a sluggish liver.

Tuberculosis Deaths Decline Among Alberta Indians

Deaths from tuberculosis among the Indians of Alberta are now about one-third as numerous as they were five years ago. The total in 1952 was 34, compared with about 90 in 1947. Among the three bands co-operating fully in the chest x-ray and treatment programs undertaken by the Indian Health Services, no deaths occurred. The three bands are the Blackfoot, Peigan, and Sarcee.

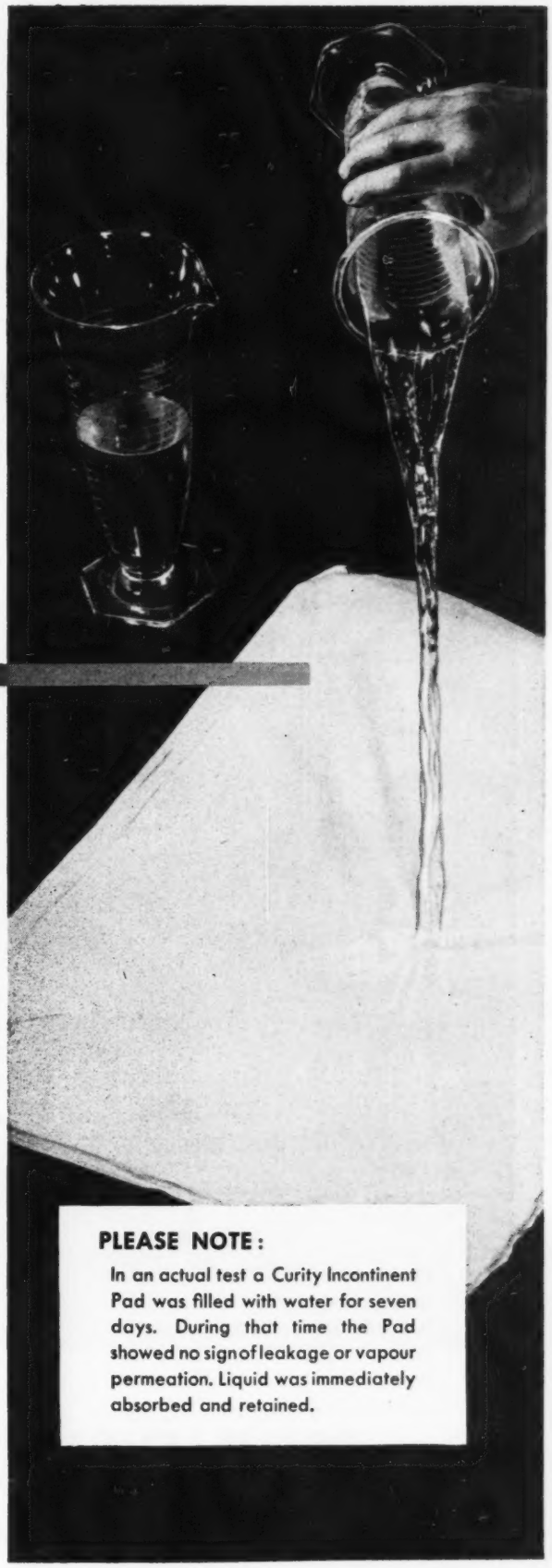
During the past year, 381 Alberta patients received treatment for tuberculosis at the Charles Camsell Indian Hospital, Edmonton, the federal health department's main treatment centre for Indians living in Alberta and the Mackenzie district.

The First Lesson

Perhaps the most valuable result of all education is the ability to make yourself do the thing you have to do, when it ought to be done, whether you like it or not. It is the first lesson that ought to be learned.—*Thomas H. Huxley*

Now Save linen laundry, time and money

with the new Curity underpad that can't leak through



Without a doubt this is the greatest hospital money saver in years! The savings made in linen, laundry, nurses' time, and money more than pay for these Curity underpads—the pads with *waterproof plastic bottom sheets.*

The new *Skintex* top sheet lets drainage penetrate immediately to absorbent inner layers. Wet or dry, *Skintex* feels like skin, promotes patient comfort, and is actually 39% stronger, more tear-resistant than regular paper top sheets. Soft, fluffy absorbent filler is 60% thicker and holds more drainage than any comparable underpad. For added comfort and protection, the waterproof plastic bottom sheet has "traction", won't slide from under patients.

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Curity
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INCONTINENT PADS

TODAY

Let them start paying for themselves in savings now!

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(BAUER & BLACK)

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In an actual test a Curity Incontinent Pad was filled with water for seven days. During that time the Pad showed no sign of leakage or vapour permeation. Liquid was immediately absorbed and retained.

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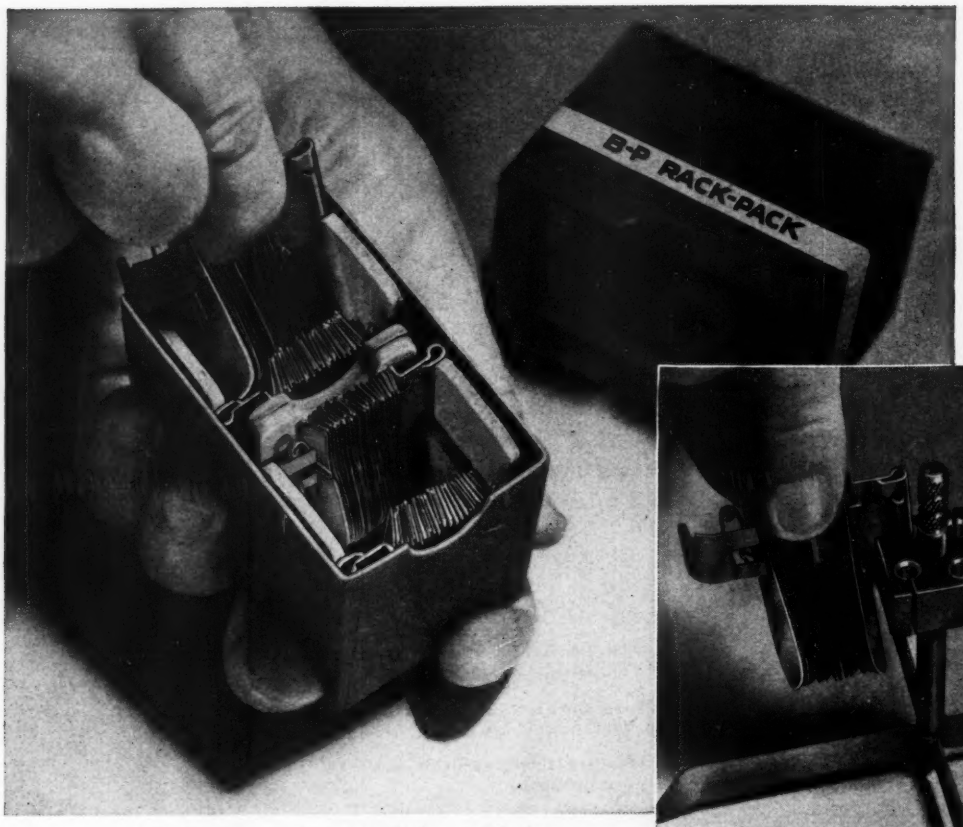

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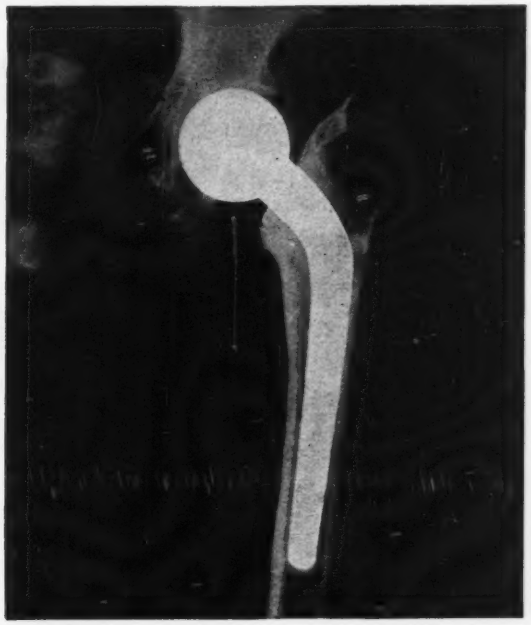

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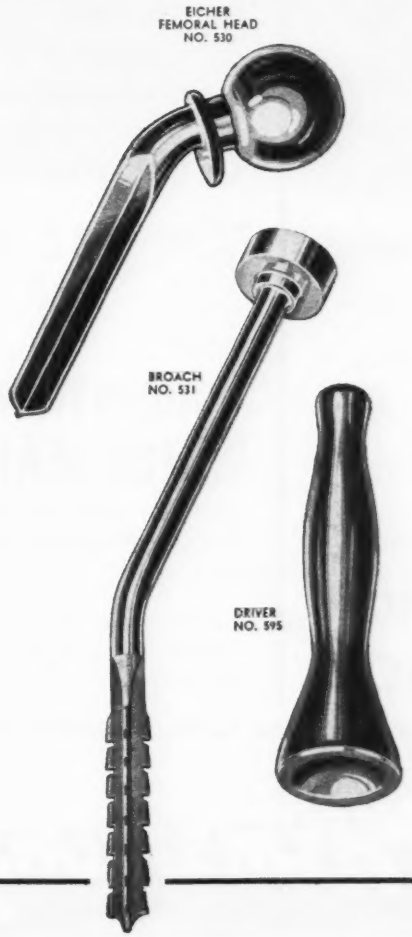

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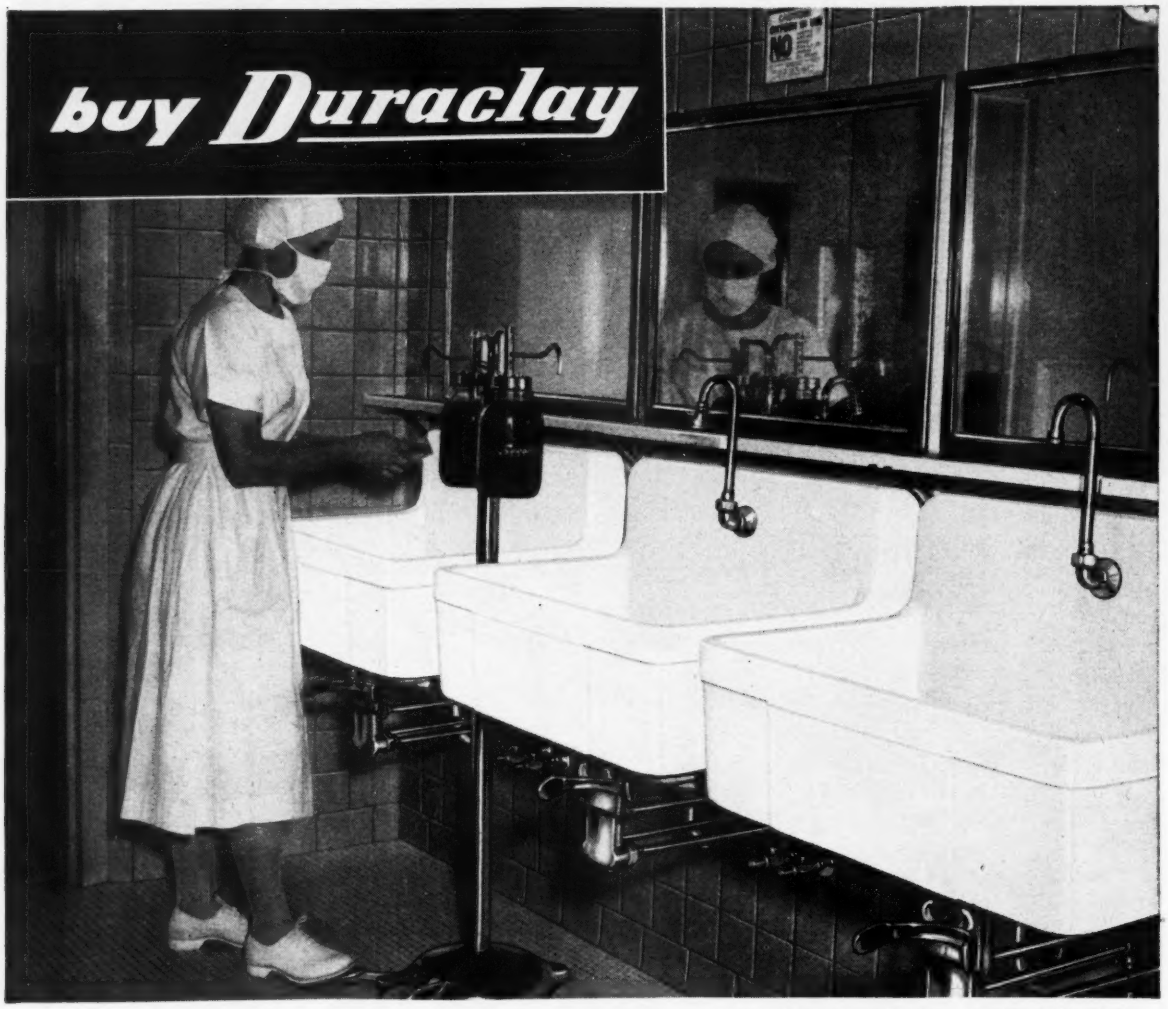

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A. L. Swanson, M.D., Editor

The CANADIAN HOSPITAL

Toronto, June, 1953 Vol. 30 No. 6

Obiter Dicta

What About This Nursing Problem?

IS THERE a nursing shortage in your area? Are there too few young women entering your nurses' training schools? Do we discourage our young nurse graduates with inadequate salaries, unfavourable working conditions, or a training course that, at three years, is too long?

These are just a few of the questions that have been asked again and again in hospital and medical circles. In an attempt to answer these queries, there have been more than a dozen surveys during the past few years by governmental and professional organizations. Most of these surveys have resulted in sound conclusions that have improved the lot of nurses with higher salaries, better hours, and improved working or training conditions. But, although considerable good has come out of most of the surveys, many of the recommendations have not been carried out. They have remained unimplemented only to be rediscovered and restated in subsequent investigations. In reviewing the recent surveys, the most significant findings show that several good recommendations have been made repeatedly without any action.

In the light of the oft-repeated questions on nursing, the three most directly interested organizations, the Canadian Nurses' Association, the Canadian Medical Association, and the Canadian Hospital Council, have each appointed committees which have met together as a Canadian Commission on Nursing. It is the objective of this Commission to review the many reports that have been made on nursing and, with this information, plus the special knowledge available to our individual organizations, to formulate a definite plan of action.

The Canadian Commission on Nursing does not contemplate another major field survey. So many have already been made and so much data is already available, that another field survey would be unpopular and unnecessary, as well as costly. The Commission *will* require co-operation from hospital, medical and nursing people for ideas, suggestions, and additional information. Indeed, such co-operation will be the life-blood of the Commission's efforts.

Although the actual shortage of nurses does not appear to be acute, except during the summer holiday season in certain areas, very few areas would appear to have a satisfactory sufficiency. The employment of nursing aides, practical nurses, and other types of auxiliary nursing personnel, has largely offset the discrepancy between the increase in hospital beds and occupancy rate, and the smaller increase in available registered nurses. However, the number of beds is continuing to increase as is our population and the tendency for Mr. and Mrs. Citizen to utilize the hospital. The occupancy rate, therefore, remains high and the demand for professional nurses will continue as additional new beds are provided. Coupled with this gradually expanding need for nurses, which should continue for a considerable period of time, is the murmur, from several sources, that the ratio of nursing auxiliaries to registered nurses has gone as high, or nearly as high, as advisable if professional care standards are to be maintained. It would appear that we cannot count on greatly increasing the ratio of auxiliaries to nurses while, at the same time, the total number of all types of nursing personnel must be enlarged steadily.

The Canadian Commission on Nursing has concluded that, beginning as soon as possible, a definite, continuing effort must be put forth to ensure the adequate provision of nursing care for our patients, now and in the future. Probably the number of young women entering the profession is nearly sufficient for present needs but, until

our population and hospital utilization level off, the need for more trainees will increase. Unquestionably, ways must likewise be sought whereby young women will be encouraged to remain in the profession following graduation. We cannot and would not deny young women the right to marry although marriage causes the greatest attrition in nursing ranks. Hundreds of young graduates marry within the first year of graduation, many never practising, once their training period is completed.

Surely this is a challenge to all of us who work with or as nurses. Surely we can make nursing practice sufficiently engaging and attractive as to encourage young women, not only to enter training, but, more important, to practise for at least a year or two before commencing their careers in marriage and motherhood. The Canadian Commission on Nursing is confident that, with the support of our organizations' members, the solution can be found. Look for the publication, "A Memo to the Doctors of Canada", which is being sent to every doctor in Canada and to hospital administrators and directors of nursing. With your help this is but the beginning of a long-term, co-ordinated campaign to solve the major nursing personnel problems.

In Hospital Planning— Make Sure of Your Funds

IN RECOUNTING his experience as chairman of a hospital fund raising campaign, a well-known business executive in an eastern Canadian city recently expressed the opinion that all planning for new construction should be completed in detail before a public campaign for funds is launched. In that way, he said, the hospital board would know exactly how much money was needed. Construction, therefore, could begin immediately the required sum was collected — and be completed before prices could rise further. Evidently the speaker was not in a position to realize that his suggestion is quite unfeasible.

In planning for a hospital addition or, even more, in considering a completely new hospital, there are literally hundreds of major details to consider before we can even begin to arrive at a cost figure. Most of us, as administrators or trustees who grasp the complexities of hospital construction and operation, have agreed that any major hospital construction should be discussed with several independent experts — the architect and the hospital consultant, to name the two most commonly employed. The number of beds needed and the type of beds are two of the most basic questions that may well call for even more specialized consultation from population-economists or others, in the initial stages of planning. A large outlay of time and money, therefore, must be spent in the planning stages and hospitals cannot risk the loss of thousands of dollars expended for plans which would have to be scrapped should the necessary funds not be forthcoming.

Architects and other experts must be paid for their services. Often eight or ten plans may be developed by the architect before one is accepted by the board of trustees. Before any definite, final plan can take shape, the hospital administration must have a good idea of how much money can be raised. There is little point in deciding that the hospital should have "x" facilities costing "y" dollars to discover that only "y minus" dollars can be found. And this is not the whole story for, as we have fewer dollars for fewer beds, so the provincial and federal governments will lessen their total contribution. Most hospital communities, therefore, feel that they cannot afford to go as far as complete sketch plans — much less working drawings — until they have some idea of how much money can be raised.

The usual procedure is to have an architect or consultant, or both, work out a general plan of the construction required and make a preliminary estimate of the cost. This forms the basis for a fund raising program. Only after the campaign can the hospital board obligate itself to the considerable expense of ordering completed sketch plans, working drawings, and detailed specifications.

The same speaker deplored the engagement of professional fund raising organizations, suggesting that every community has a good many capable executives (sometimes a number of retired business men) who would be interested in handling such work and would do so at no cost. In actual practice, especially in larger centres, the record of campaigns organized by specialists in that field has been better than those where non-professional organizers were in charge. There is also less danger that direct pressure will be bought to bear on commercial firms or individuals to make large contributions — reluctantly — in order to enhance their prospects of future business. Moreover not many hospitals can acquire, without cost, the influence of a campaign committee made up of "big names".

12th Biennial Meeting

THE 12th BIENNIAL meeting of our association held last month in Ottawa gave evidence that Canadian hospitals are moving steadily ahead in their national organization and activity. This issue of *The Canadian Hospital* contains Dr. O. C. Trainor's presidential address (in which he makes strong recommendations pointing the way to future progress) and also further information about the meeting in report form.

"Official Journal—Canadian Hospital Association" is one new phrasing that may strike the reader's eye. The new name may take some getting used to (especially for the central office staff in answering the 'phone and writing letters). However, it should be more meaningful to our many fraternal organizations in recognizing Canadian hospitals as a national force. At the biennial meeting, too, official approval was given to the new Canadian Hospital Association crest which will shortly make its appearance on the cover of this journal.

This month, the masthead of *The Canadian Hospital* lists the names of our new board of directors. The observant reader may note that the number of directors is increased by one. The larger group enables representation to cover all sections of the country more completely. Our congratulations to Mr. John Smith of Yorkton, Sask., to Mr. A. J. Swanson and to Rev. Father John Fullerton of Toronto, the new members, on their election.

Presidential Address to the

Canadian Hospital Council

O. C. Trainor, M.D.
Winnipeg, Man.

TRADITION has ordained that at each biennial meeting your president shall deliver an address. In the main this address should embrace two objectives. Firstly, to acquaint you in rather broad perspective with the activities and achievements of the Council since the last biennial meeting—a form of apologia for his period of stewardship—and secondly, to attempt to chart a course for the future, as may appear warranted by the experiences of his term of office. The first may be but a recital of facts with which you are probably all quite familiar and for which the major credit and responsibility rest on others than himself—the board of directors and the executive staff. Nevertheless, the two years since last we met together in this room have been a period of much positive achievement and one fraught with a multiplicity of difficult and thorny problems with which your executive have had to deal.

During its early formative years, this council was able to fulfill the purpose of its foundation largely through the faith and support of its founding fathers, but more particularly through the efforts of its first executive secretary, Dr. Harvey Agnew. We are all deeply sensible of the debt we owe him and I am happy to announce again, that he is to receive the George Findlay Stephens Memorial Award which has now come to represent the most signal honour which can be paid to any individual by the hospital fraternity in Canada. I am sure you will all agree that he is richly reserving of the distinction.

Appointments and Activities

At the last biennial meeting, Mr. Armstrong announced the appointment of an assistant executive secretary, in the person of Mr. Murray Ross, and also had to inform you of that staggering and, as it then appeared, almost irreparable loss, the resignation of Dr. Agnew as executive secretary. We had all become so accustomed to thinking of the Council in terms of Dr. Agnew that at first sight there did not appear to be any alternative replacement. Mr. Armstrong, however, was able to announce our good fortune in securing the services of Dr. L. O. Bradley and pointed out the efficient and capable manner in which he and Mr. Ross were filling the void. Unfortunately, however, Dr. Bradley's tenure was but short-lived and again your Board of Directors were faced with a problem of succession.

It speaks well of the reputation which the Council has attained among the hospital people of this country that we were able to obtain a highly qualified and competent replacement for Dr. Bradley in the person of Dr. A. L. Swanson, our present Executive Secretary. Most of you will already have met Dr. Swanson and will, I am sure, agree that in the short time he has held the office of Executive Secretary he has succeeded in filling this position in the best traditions of his distinguished predecessors.

O. C. Trainor, M.D.

Two years ago, Mr. Armstrong also announced our good fortune in securing the services of Mr. Donald MacIntyre to head up the new venture of the extension course in hospital organization and management which the Council was able to initiate and carry out through the generous support of the W. K. Kellogg Foundation and the co-operation of the School of Hygiene, University of Toronto. I would like at this juncture to express our grateful thanks to the Directors of the Kellogg Foundation and more particularly to its successive hospitals division directors, our good friends, Graham Davis and Andrew Pattullo. The outstanding success of this undertaking is, I think, evidence that they built even better than they knew. In addition, Mr. MacIntyre and the Committee on Education are entitled to a major share of the credit for the outstanding success of this course. Mr. MacIntyre, as assistant secretary, has also carried a considerable share of the work of the executive office.

A new extension course for medical record librarians is now under way, again with the financial support of the W. K. Kellogg Foundation. The preparation of this course is a project of the Canadian Hospital Council and the Canadian Association of Medical Record Librarians and is under the direction of a joint committee. Administrative supervision is under Mr. MacIntyre and Miss Doris McPherson, a registered nurse as well as a registered record librarian, who is engaged full time in lesson preparation.

Realizing, as you must, the difficulty of obtaining qualified medical record librarians in this country, you will no doubt appreciate the importance of this training course to Canadian hospitals.

A Canadian hospital directory containing most of the pertinent information often required concerning each of our hospitals has recently been prepared and it will be in your hands shortly. I am happy to inform you that the full cost of providing a copy of this very useful publication to each hospital will be met from advertising revenue.

The report of the Committee on Accounting and Statistics, presented at the meeting two years ago, again recommended the compilation of a standard accounting manual, but, further, held out a definite hope that this long-wanted project might be carried through.

I would be remiss if I did not remind you that the *Canadian Hospital Accounting Manual* — CHAM — was published about a year ago, produced with the co-operation and financial assistance of the Federal Government and the government of Ontario, which assistance is gratefully acknowledged. I think it no exaggeration to say that no effort of the Council since its inception is likely to have such a profound and lasting effect for good as this same CHAM. I am sure Mr. Ward will support me when I say that, reinforced by numerous accounting institutes across the nation,CHAM has already worked a minor revolution in the accounting and financial practices of Canadian hospitals. I wish to pay tribute to our successive Committees on Accounting and Statistics which have led us to the goal which our present committee, under the chairmanship of Mr. Walter Dick, has seen reached. I would also pay tribute to the efforts of our Associate Secretary Murray Ross (a former Chairman of the Committee) on whose shoulders the main burden of administrative responsibility fell, and to his associates, Messrs. Robert Clements, the technical director, Paul Shannon, Paul Olivier and the many others in hospitals and in departments of the federal and provincial governments, who helped see this task through.

Accreditation

Mr. Armstrong, in his presidential address, two years ago raised the question of hospital standardization and accreditation and the incoming Board of Directors were instructed to make a comprehensive study of this important question by means of a special committee which was named at the meeting. By implication they were thus authorized to represent Canadian hospitals in this regard. Under this mandate your committee entered into an association with committees from the Canadian Medical Association and the Royal College of Physicians and Surgeons of Canada in the formation of a joint study group which was named the Canadian Commission on Hospital Accreditation. One of the Canadian Medical Association seats on this Commission was allotted to l'Association des Médecins de la langue Française du Canada and an invitation has been extended to the Catholic Hospital Council of Canada to accept one of the Canadian Hospital Council seats.

After the Commission was formed it seemed that a completely Canadian program of hospital inspection and accreditation would be feasible with the financial support of government funds. For a time it appeared probable that such funds might be made available and the associations and conferences were asked for approval and support. A majority of our constituent members expressed approval and promised financial support which is a very convincing indication of basic Canadian thinking on this subject. However, the hope for financial participation of the federal government in this project did not develop and I think therefore that because of the financial implications the proposition must be re-examined. There is a basic principle, however, which I cannot emphasize too strongly, namely, that under the changed set-up of hospital inspection and accreditation on this continent, any group that purports to inspect and accredit Canadian hospitals must, on its policy-making level, accord official recognition to Canadian hospitals through their official association, the Canadian Hospital Council.

This whole question of hospital accreditation has assumed such importance that it has been given a major place on the program of this meeting. You will have ample opportunity to discuss it from all aspects; and you will be expected to give definite and specific instructions to the incomng Board of Directors by way of a resolution.

Change in Name

I think I have, perhaps, covered the highlights of Council activities during the past two years. The presentation is, however, sketchy and incomplete. The day-to-day activity of the Council, through its executive office, constitutes a constant effort on your behalf, impossible to cover in detail in one report. I have been forced to delete such important questions as unemployment insurance and federal grants in both of which the Council has rendered signal service to Canadian hospitals. This but points up the ever expanding importance of the Council as the official voice of our hospitals on the federal level. It is becoming all too evident that a convention at two-year intervals is becoming inadequate to ensure proper liaison between this policy-making Assembly and the Directors. As a practical solution you will be asked to consider an amendment to the constitution.

First, it is proposed that we change the name of this organization from Canadian Hospital Council to Canadian Hospital Association. This change of name is purely a matter of convenience and does not connote any change in the constitutional set up of the organization. The term Council would seem no longer properly descriptive of the role of the national organization in the hospital field. This is particularly true outside the country and it has been thought there has been some misunderstanding of the essential national prerogatives and responsibilities of this organization when the interests of Canadian hospitals are involved. I trust you may see fit to approve this change in name.

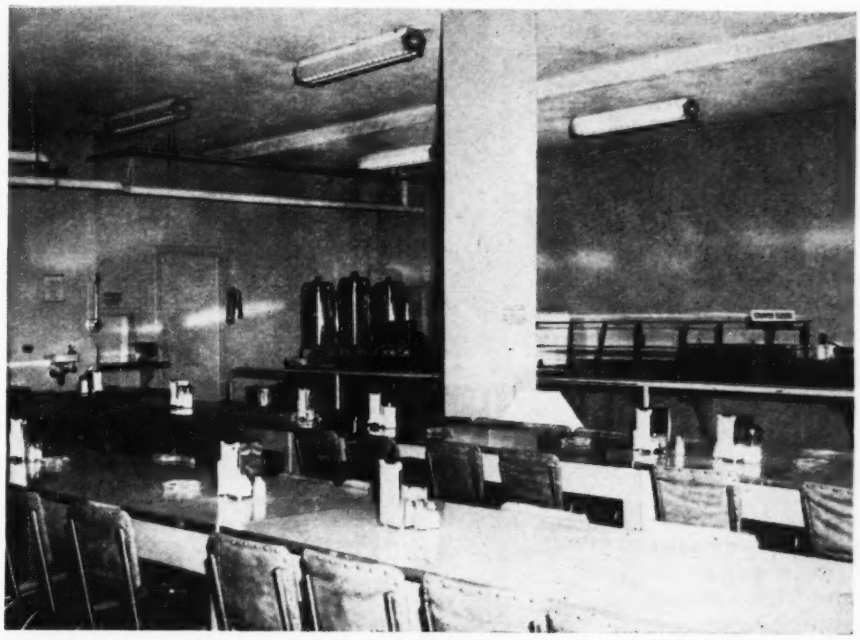
Secondly, a proposal will be put forward that, in the off year between biennial conventions, a meeting of the presidents and secretaries of all the member organizations be convened to aid the executive in the interpretation of policy and assist in the final formulation of the vitally important policy decisions. It is my hope that you may see the necessity for this move and that the proposal may meet with your approval.

The Future

This brings me to the second and what might be termed the constructive part of my address. What of the future?

While the constitutional set-up of the Council has served reasonably well in the past, it is becoming more and more inadequate to allow it to fulfill the purposes of a national association. In the first place, it is not properly representative, particularly with re-

(Continued on page 116)



New snack bar, Vancouver General Hospital

Modernizing Dietetic Facilities

Paula R. Reber,
Director of Dietetics,
Vancouver General Hospital,
Vancouver, B.C.

VANCOUVER General Hospital's dietetic department has been suffering from growing pains for the past five years. Following a hospital-wide survey in 1947, a plan for the department's future growth and development was drawn up. We are still working on that plan and there is still much to be done.

Our main building was originally an E-shaped type of building and is well over 40 years old. The dietetic department is housed in the centre bar of the E, occupying the basement, second and third floors. The basement is used as a receiving area for bulk deliveries of food and for meat and vegetable preparation. These activities, while all in the basement, did not previously take place in adjacent areas. All areas were dark, poorly ventilated, inadequate in size and equipped for the most part with worn equipment well past its prime. Adequate refrigeration was woefully, even dangerously, lacking.

Therefore, a plan of modernization was drawn up and this work was completed in the spring of 1952. Some of the highlights of the renovated area are described below.

Highlights of Renovation

A modern crushed ice machine with a capacity of 4,750 pounds of crushed ice daily is one of the welcome new features. In years gone by, we crushed great blocks of ice, by hand, in an ancient machine—which nearly always had some missing teeth.

To the left of the ice machine is our new and modern meat cutting room. This is connected by overhead rail to the adjacent delivery entrance. Meat carcasses are fastened to the rail on the truck and roll by gravity down to the meat room where they are weighed in on a track scale and then continue into the refrigerator. The track continues out through the second door and out over the meat saw. The work table for the meat saw is made of stainless steel. Two of its legs are on castors to facilitate movement of carcasses into the best cutting positions. The other two legs are fitted with rubber cups to prevent the table from shifting, thus lessening the accident hazard. The meat saw is fitted with an industrial light designed to eliminate shadow. All shelving in basement refrigerators is slatted metal, is on castors, and is designed in easily mobile sections.

Diet Kitchen

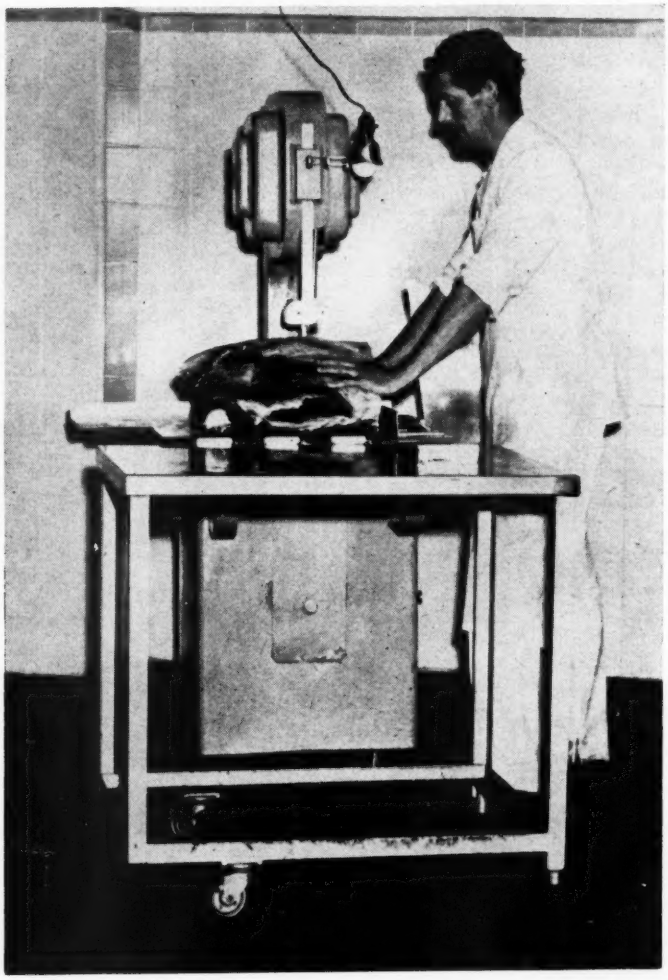
The diet kitchen is directly across the corridor from the meat room. Many of the overhead pipes which previously ran through this corridor have been eliminated. Steam and plumbing facilities are channeled through an underground duct and the corridor is paved with red mastic tile. This tile is easily removable when repairs are necessary and provides a smooth and even surface for the constant stream of traffic which passes through the area.

The diet kitchen does not boast anything very original in the way of equipment, except that its many drawers and cupboards were designed in depth and width to hold exactly what

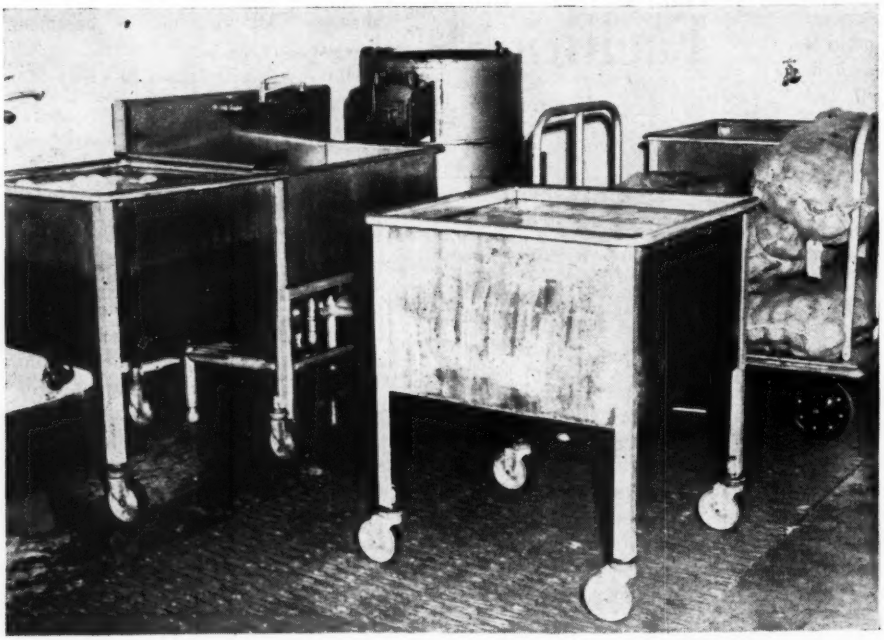
is in them. We still find a diet kitchen a very essential work area. The size and scope of our new area was never more appreciated than during the poliomyelitis epidemic when we had dozens of orders for tube feedings for patients who had undergone tracheotomies. Our hospital is a busy one where over 20 per cent of our patients are on therapeutic diets and we expect to continue using a diet kitchen for variations from our normal menu. Diet kitchen food is transported to the ward kitchen in enclosed unheated food trucks. It is put up on trays which slide into place on a metal tray rack open on both sides. Custards, jellies, junkets, gastrostomies, and juices are housed at easy reach in refrigerators from which they are collected by the wagon men at loading time.

Next to our diet kitchen is our wagon room where we store, pre-heat, and clean the 26 food wagons used at each meal in our hospital. This room is easily visible from the dietitian's glass-walled office which also looks out into the diet kitchen on the other side. The wagon room opens into the lift room. The electric food lifts connect with the hospital's main kitchen on the top floor. In future, the food wagons will all be loaded, checked, and dispatched from the basement level. At present, they travel by elevator—passenger elevator—to the top floor to

(Concluded on page 90)



The meat cutting table has two legs which are mobile and two which are fixed.



The potato preparation area. Note potato peeler and portable tubs.

C.H.C. votes to take active part in

Accreditation Service

Arnold L. Swanson, M.D.

IN A MEETING lasting until a few minutes past midnight, delegates to the 12th Biennial Meeting of the Canadian Hospital Council voted to join with the Canadian Medical Association, l'Association des Médecins le Langue Française du Canada, and the Royal College of Physicians and Surgeons of Canada in expanding hospital accreditation service in Canada.

The special meeting saw every delegate rise to express the views of his respective organization and ended with a unanimous vote to support the new program which is regarded as a compromise between the service offered by the Joint Commission on Accreditation of Hospitals and a purely Canadian program. If also ratified by the other Canadian organizations, it is expected that the proposed plan will offer Canadian hospitals twice the survey service previously rendered, direct representation on the Joint Commission, and the continuing advantages of a Canadian study group, known as the Canadian Commission on Hospital Accreditation.

Information on Accreditation of Hospitals*

On December 1st, 1952, a memo on the subject of a Canadian Commission on Hospital Accreditation was circulated to the member associations and conferences of the Canadian Hospital Council. This memo summed up briefly the development of accreditation activity in Canada leading to the formation of the Canadian Commission on Hospital Accreditation. It also contained the recommendation by the Canadian Commission that a Canadian program be instituted; and included a resolution calling for such a program. The member organizations of the Canadian Hospital Council were requested to consider the matter and cast their votes by mail to the Executive Secretary. In reply to some questions that arose out of the first memo, a second memo was sent out on December 11th, 1952.

Voting on Resolution

According to the Constitution, a resolution submitted to the members of the Council by mail requires a two-thirds majority in favour to be accepted. However, in view of the importance of this particular matter, it was felt that unanimity or near unanimity was required before such a far-reaching step could be taken.

The final vote was as follows:

	By Organization	By Delegates†
In favour	9	18
Against	2	4
Wish to defer for further consideration	5	13

The tabulation of the vote revealed that, although a majority were in favour, a conclusive mandate was not given. Several members, while favouring the proposal in principle, earnestly requested time for further consideration, some specifically stating that they would desire to have the matter discussed at the Biennial Meeting. Two of those voting in favour also suggested that more time be given for discussion. Most of those deferring, nonetheless, endorsed the proposal in principle.

Development of Accreditation—The Joint Commission

Accreditation of hospitals has been carried out since 1918 when the American College of Surgeons inaugurated its "Standardization" program. At the time of the 1951 Biennial Meeting of the Canadian Hospital Council, arrangements were under way in the United States for the transfer of this accreditation activity from the American College of Surgeons to a Joint Commission on Accreditation of Hospitals. This transfer took place January 1st, 1953.

Accreditation of hospitals has always been on a voluntary basis and has included Canadian as well as United States' hospitals. The Joint Commission proposes to continue this policy. Membership on the Joint Commission is as follows:

American College of Physicians 3 seats

**Most of the information contained in the remainder of this article is extracted from a memo circulated to all member organizations of the Canadian Hospital Council on April 17, 1953.*

†The difference in tabulation by delegate votes is caused by the fact that one association has four votes and another three. All other member organizations have two delegate votes.

Adopted Proposals on Accreditation

1. THAT the Canadian Hospital Council reaffirms the previous recommendation that an exclusively Canadian program of hospital accreditation is desirable;
2. THAT it is now recognized that the institution of such a program is not feasible at present, owing to inability to secure sufficient financing;
3. THAT it is therefore agreed that co-operation with the Joint Commission on Hospital Accreditation offers the best prospect for the operation of a hospital survey program at the present time;
4. THAT it is agreed the Canadian Hospital Council shall seek direct representation on the Joint Commission;
5. THAT the Canadian Hospital Council recommends to its constituent organizations participation in the survey of the Canadian hospitals through the financing and employment of an additional inspector by the Canadian Commission, on the same basis as those presently employed on behalf of the Joint Commission, at a cost to the Canadian Hospital Council not to exceed $12,000 annually;
6. THAT it is recommended to the constituent organizations that the Canadian Commission on Hospital Accreditation continue to function on behalf of Canadian interests.

American College of Surgeons	*3 seats*
American Hospital Association	*7 seats**
American Medical Association	*6 seats*
Canadian Medical Association	*1 seat*

Canadian Hospital Council Committee

There was considerable discussion on accreditation at the 1951 Biennial Meeting. Papers were read by Dr. Paul S. Ferguson of the American College of Surgeons, by Mr. George Bugbee of the American Hospital Association, and by Dr. A. D. Kelly of the Canadian Medical Association. The possibility of establishing a Canadian program was discussed as were the functions of the new Joint Commission. No decision was reached and it was resolved that "The Canadian Hospital Council set up a study committee to examine the matter and make a full report to the Canadian Hospital Council on the most feasible and practical plan to develop an adequate hospital standardization program for Canadian hospitals".

Several committee meetings were held and, in January, 1952, this committee, which was named the Committee on Association Relations, met with the Canadian Medical Association Committee on Hospital Standardization and with representatives of the Royal College of Physicians and Surgeons.

Canadian Commission on Accreditation

The members of the three organizations named their joint meeting the "Canadian Commission on Hospital Accreditation" to indicate its distinction from the "Committees" of individual organizations, and also to point out the similarity of purpose to the Joint Commission. The Canadian Commission is a study group. It is not incorporated or in any way empowered to begin a program of hospital accreditation, although it could, with the consent of all the member organizations, form the nucleus for such an incorporated body.

The objectives of the Canadian Commission on Hospital Accreditation are as follows:

1. To conduct an inspection and accreditation program which will encourage Canadian physicians and hospitals voluntarily.

(a) to apply certain basic principles of organization and administration for efficient care of the patient;

(b) to promote a high quality of medical and hospital care in all its aspects; and

(c) to maintain the essential diagnostic and therapeutic services in the hospital through the co-ordinated effort of the organized medical staff and the governing board of the hospital.

2. To establish standards for hospital operation and to assist hospitals to attain these standards.
3. To recognize compliance with standards by the issuance of certificates of accreditation.
4. To assume such other responsibilities and to conduct such other activities, particularly of an educational nature, as are compatible with the operation of a hospital accreditation program.

The members of the Canadian Commission on Hospital Accreditation are:

Canadian Hospital Council: (5 seats)*

Dr. A. Lorne C. Gilday, Montreal (Chairman)
Dr. O. C. Trainor, Winnipeg
Rev. Father H. L. Bertrand, Montreal
Dr. W. Douglas Piercey, Ottawa

Canadian Medical Association:

Dr. E. K. Lyon, Leamington, Ont. (Vice-Chairman)
Dr. D. A. Thompson, Bathurst, N.B.
Dr. A. M. Goodwin, Winnipeg
Dr. N. W. Philpott, Montreal

L'Association des Médecines de Langue Française du Canada: (1 seat)

Dr. E. Thibault, Verdun, P.Q.

Royal College of Physicians and Surgeons of Canada: (2 seats)

Dr. H. K. Detweiler, Toronto
Dr. A. D. McLachlin, London

The Canadian Commission recommended a Canadian program of accreditation closely parallel to the Joint Commission in objectives and functions. It was decided that the constituent members could not provide sufficient funds to operate such a program and that financial assistance from the federal government would be required.

It was felt advisable to obtain all possible information before laying the matter before the members of the constituent organizations. Negotiations were therefore begun with the Canadian Government to ascertain whether or not financial support would be available. However, as these negotiations with Ottawa became protracted, it was decided that no more time should be lost in approaching our members. Pending decision by the government, the Executive Secretary of the Canadian Hospital Council was therefore directed to word the resolution that was sent out December 1st, 1952, asking for support of a Canadian accreditation program.

It was estimated that with government assistance a very superior program could be offered Canadian hospitals. If government aid was refused by hospitals or denied by the government, a Canadian program would offer independence and stimulation of thought and action, but no more inspection service than presently offered by the Joint Commission. It was necessary to have the opinion of our member organizations before proceeding further and, accordingly, on December 1st, 1952, the accreditation resolution was sent out.

Meeting of Canadian and Joint Commissions

The possibility of a compromise between the Joint Commission program and a purely Canadian program had also been considered for some time. This thought has been lent considerable impetus by recent information that federal funds will not be available to us, at least for the present, and by the fact that C.H.C. member organizations did not give a positive mandate to proceed with a Canadian program. Accordingly, a meeting between the Canadian Commission on Hospital Accreditation and the Joint Commission on Accreditation was held on April 6th, 1953, in Toronto, with Dr. Gunnar Gunnarson, Dr. Edwin Crosby, and Judge Milton George representing the Joint Commission.

The meeting was marked by frank discussion and close understanding throughout. Dr. Crosby, on behalf of the Joint Commission, noted that the Joint Commission would hope to assist Canada whatever the decision on accreditation might be in this country.

Prior to the meeting with the Joint Commission, the Canadian Commission agreed on the following points

(Concluded on page 60)

**The seventh A.H.A. seat is filled by a Canadian appointed by the A.H.A.—Judge J. Milton George of Morden, Manitoba.*

**One C.H.C. seat has been made available to the Catholic Hospital Council of Canada. The Catholic Hospital Council of Canada may, therefore, appoint the representative for the fifth C.H.C. seat if desired.*

Evaluation of Enrichment Program

W. H. Sebrell, Jr., M.D.,
Director,
National Institutes of Health,
United States Public Health Service,
Washington, D.C.

WE ARE inclined in these modern times to take our knowledge of nutrition for granted and to underestimate the importance of its application. Consider for a moment the problem of malnutrition in earlier days. Vasco de Gama, in his search for a water route to the East, rounded the Cape of Good Hope and returned with only a third of his crew, the rest having died of scurvy. In the late nineteenth century, 40 per cent of the seamen in the Japanese navy died of beriberi; and in Italy, at about the same time, the reported cases of pellagra exceeded 104,000. One by one, these and other serious diseases resulting from specific dietary deficiencies have yielded to science.

The progress of nutrition research, however, is only part of the story of effort in the nutrition field. The complete picture includes what might be termed the public health movement—the application of nutrition knowledge, through industry, agriculture, education, government and, of course, the medical profession. In this movement, an important trend in Europe and North America has been a broadening of the attack to extend preventive measures to successively larger groups of people.

Available knowledge prior to World War I was used mainly for the prevention or alleviation of dietary deficiency diseases in the individual. Citrus fruits and juices were fed to seamen, and later to children, to treat and prevent scurvy; cod liver oil was used for treating rickets; and extracts of rice polishings, for beriberi. The next step, an organized public health approach, was the planned distribution of preventive dietary supplements, such as cod liver oil, butter, and iodized salt. Meanwhile, the isolation of vitamins progressed; and, just prior to World War II, it became practical to improve stable foods with synthetic nutrients as a means of preventing dietary diseases in large populations.

From an address presented at the first Nutrition and Enrichment Conference, Toronto, Ont., Jan., 1953.

Enrichment in the United States

In the United States, on a growing scale, vitamin D was added to milk and vitamin A to margarine. Thus the principle being used in the control of goiter with iodized salt—the fortification of food—was extended to rickets and vitamin A deficiency. Early in 1941 the same broad approach was applied to the prevention of beriberi, pellagra, ariboflavinosis, and iron-deficiency anaemia, when enriched bread and flour were introduced.

Public preference for highly refined foods had left the American diet deficient in many important respects. For example, the patent milling process, by removing most of the germ and bran shorts from flour, reduces the thiamine content about 90 per cent and the niacin, riboflavin, and iron 70 to 85 per cent. White bread and refined sugar and fats are widely preferred for taste, appearance and durability. Together they furnish a large proportion of our calories. This resulted in less than satisfactory amounts of essential nutrients per capita, and led inevitably to dietary diseases, especially in poorly fed sections of the population.

The enrichment of bread and flour had, therefore, received the enthusiastic endorsement of the nation's foremost nutrition scientists, including the American Medical Association's Council on Foods and Nutrition and the National Research Council's Food and Nutrition Board. With the advice of these groups, the Food and Drug Administration established standards for enriched wheat products, permitting specified amounts of the four nutrients, thiamine, niacin, riboflavin, and iron. Certain other substances, such as calcium, vitamin D, and wheat germ, can also be added, but this has not been done on a wide scale. Calcium and other nutrients are often supplied through use of dry milk solids in bread, a practice that should be extended.

By the time the United States entered World War II, the enrichment of flour and bread had become well established. Within another year about three quarters of the bakers' white bread and almost all family flour was enriched on a voluntary basis. A further step in the application of nutrition knowledge was now feasible—nation-wide control of specific dietary diseases; and a program to that end was soon launched. During periods of war, foods which are costly to produce tend to become scarce, and greater dependence is placed upon cereal products, the least expensive foods in terms of man-hours and acreage. Consequently, it was apparent that cereals as an important part of the national diet must contain essential nutrients.

Serious consideration was given to the possible use of long-extraction flour, which retains some of the vitamins and mineral-rich portions of the wheat. Some reasons against requiring the product, besides the general preference for white flour, were its perishability, its limitations for pastry, and the dependence of the animal feed industry upon the residues of patent milling. Moreover, it was believed that the prohibition of white bread and flour would be difficult or impossible to enforce in the United States. There was also the success achieved with voluntary enrichment, as well as the fact that enriched products were better supplied with the nutrients in question—an important health consideration.

In January, 1943, the Federal Government issued War Food Order No. 1, requiring the enrichment of all bakers' white bread with thiamine, niacin, riboflavin, and iron. Subse-

quently, the nation-wide nutrition movement brought about improved agricultural practices, better nutrition education, a national school lunch program, and advances in food handling preservation, and distribution. Since October 1946, when the War Food Order ceased to be effective, enrichment of bread and flour has not been required by Federal regulation, but more than half the states have passed laws making enrichment mandatory. In the remaining states, voluntary enrichment is being continued extensively, according to recent surveys by the industry.

Results

I should like now to review briefly the results of enrichment in the United States, after a nation-wide practice of more than ten years. What have been the health gains due to better nutrition, and to what extent are they attributable to the enrichment program? What, if any, have been the harmful effects? What is the future of food enrichment as a means of attacking malnutrition throughout the world?

Unequivocally, we can say that there is no evidence of harm from the program, nor reason to expect it. If the diet contains slightly more than the required amount of a nutrient, the excess is simply excreted. These statements apply also to the products commonly fortified with iodine and vitamins A and D. There is a wide margin of safety between recommended and harmful levels.

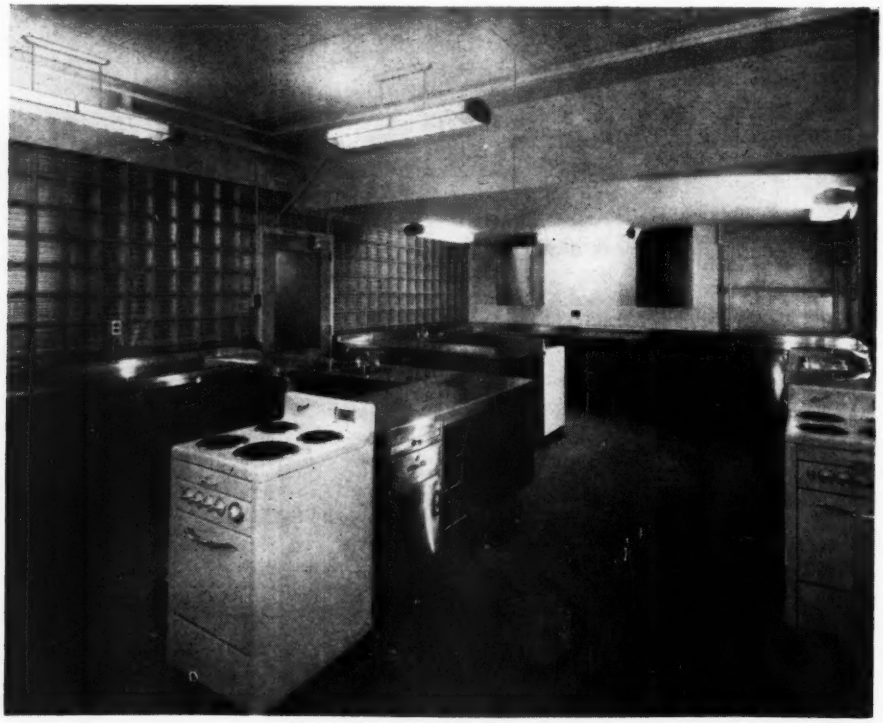
As to health gains, on the other hand, there is ample evidence of the efficacy of the nutrition program, and every reason to ascribe much of the success to bread and flour enrichment. No more dramatic history of health progress could be cited than that of pellagra in the United States. In the 1920's and 1930's this was our most serious deficiency disease.

Pellagra results from a diet low in two nutrients, either of which will prevent it—the vitamin niacin and the protein component tryptophane. Mild cases are much commoner than extreme cases, and mortality rates reflect only a small proportion of the pellagra problem. In a region of high prevalence, at least 33 cases per death were found in 1917, before control measures were instituted. At one time, an estimated 200,000 were afflicted with pellagra in the United States. In 1928, at the height of reported mortality, there were approximately 7,100 pellagra deaths, or 6 per hundred thousand population. Nearly 98 per cent of those occurred in southern states where most of the available land was used for non-food crops, such as cotton and tobacco.

For the past 25 years, the death rate from pellagra has shown a general downward trend. This is attributable not only to the national nutrition program, but also to better medical treatment, shifting of the population, extensive changes in agricultural practices, and gradual economic improvement in the South through the establishment of industry there.

It is interesting to note the pellagra mortality at key points in the nutrition program. By 1937, the year niacin was isolated, pellagra mortality was about half that of 1928, or 2.5 per hundred thousand. Cures with niacin were reported that year by several clinicians and, thereafter, the decline

(Continued on page 102)



The new cookery laboratory for student nurses at the Toronto Western Hospital →

Each compact unit of the new cookery laboratory at Toronto Western Hospital provides working space for four students.

Where Cooking is a Pleasure

EFFICIENCY and convenience are key words in describing the attractive new cookery laboratory for student nurses at the Toronto Western Hospital, Toronto, Ont. Located on the ground floor of the nurses' residence, the laboratory is arranged in six units, each equipped with an electric stove, a double sink, and ample cupboard and drawer space for every student. A refrigerator, located in the centre of the room, serves the entire laboratory. Each compact unit provides working space for four student nurses, allowing approximately 15 square feet of working area per person. The over-all area of the laboratory is 774 square feet.

Gleaming stainless steel has been used throughout the new laboratory for sinks, cupboards, and tables. Lighting is by fluorescent lamps while a glass block wall, which runs along one entire side of the laboratory, gives natural light. The bright effect is further enhanced by the soft pastel colour of the walls.

Many details have been carefully considered to add to the efficiency and usefulness of this laboratory. For instance, each drawer was planned to be just the right size for the number of utensils it would contain. Some pieces of equipment in the new kitchens perform double duty. The large main storage cabinet not only provides storage space but can be used also for teaching purposes, since its sliding panels have been treated on the outside with a green material which becomes a useful chalkboard. Comfortable stools with attractive green leather seats can be found in each unit—lift up the seat of the stool and it is a step ladder. Stoves, too, have a convenient feature in that the electrical elements can be lifted up to make cleaning easier.

While the new cookery laboratory is intended primarily for the use of first-year nursing students in their 20-hour course in food preparation, dietetic interns also use it for experimental cookery, sampling, and recipe testing. In leisure hours, the laboratory assumes another role. Situated next to the nurses' recreation room, it is often used to prepare snacks and refreshments. Food can be transferred quickly from kitchen to recreation room by means of a pass-through counter.

This year's class of student nurses had already completed their course in food preparation before the laboratory opened in January. Thus the new laboratory will not come into full use until next fall when the incoming class will be learning how to prepare food in shining, trim, and efficient surroundings—truly an inspiration for any cook.

Executive Secretary's Report

to the

Canadian Hospital Council

A. L. Swanson, M.D.

IT IS MY privilege to report to you on the activities of the Canadian Hospital Council during the past two years. You have already listened to our President's very comprehensive address. Others, as members of our staff or as close associates in our enterprise, will speak specifically on our journal, the extension courses, the *Canadian Hospital Accounting Manual*, and related activities. It therefore devolves on me to touch briefly on the many executive aspects of our work in order to present an over-all pattern on which succeeding speakers will paint the detail.

Two years is a long time—a long time between meetings of the policy-forming assembly for the guidance of directors and executive staffs, and a long time during which much requires to be done, and is done, with only the general knowledge of our members. The past two years have seen the Council continue to grow and to expand in its activities, particularly in the publishing and educational fields.

The executive and journal offices now employ a total staff of twenty-one, of which two are part-time and one is classified as temporary. Six work exclusively on the journal, six on the extension courses, and four as secretarial staff. The remaining five divide their time between secretarial and journal activities. In 1951, the staff totalled 15 including two part-time; in 1949 the staff totalled 11.

One might well inquire, why are we supporting such a large group? What is the service they render? This double-barreled question brings us to my comments on the activities of the Council.

Educational

The greatest increase in staff has been brought about by the development of the extension courses. The first of these in Hospital Organization and Management has already received wide recognition on both sides of the border and abroad. It will graduate its first two-year class this summer. The second extension course which is for the training of Medical Record Librarians has been in the process of development during the past nine months and the first class will commence this autumn. These two education projects, the first in co-operation with the University of Toronto, and the second sponsored jointly by the Canadian Hospital Council and the Canadian Association of Medical Record Librarians, have been designed in an attempt to provide a definite service to hospitals and, thereby, to our patients. Both courses have required, and will continue to require, the services of the present efficient staff group. Both courses are supported, almost in their entirety with very little direct Council expense, through the generosity of the W. K. Kellogg Foundation.

Publications

Our journal, *The Canadian Hospital*, also engages a large segment of our staff. Even more than the extension courses, the journal pays its own way (even to the extent of realizing modest profits) while at the same time providing a definite service to the Canadian hospital public. The journal depends for its success not only on the confidence of our advertisers but still more on the support of hospital people. As a professional journal its degree of excellence is dependent upon its authors. I cannot urge too strongly that you and the thousands of others operating hospitals in Canada should set your thoughts and ideas down on paper for publication. Only in this way can we offer the best available information on all topics for dissemination across the country and to foreign lands. Only by your published studies and experience may we offer a truly professional publication.

The second formal Council publication is in the form of our new *Canadian Hospital Directory*. Designed to complement rather than to replace other similar publications, the directory contains Canadian hospital listings, a buyers' guide, a listing of educational programs in hospital and related fields, and information on hospital and associated organizations. Several types of information, under one cover, are thus provided for ready reference. This production has required the services of extra staff on part-time and temporary bases to supplement the efforts of permanent journal and secretarial personnel.

The third major publication is well-known to all of you in the form of the *Canadian Hospital Accounting Manual*. Although the initial compiling, printing, and distribution, has been completed, the work of revision, education and exploitation of the manual's usefulness is a continuing process for the Canadian Hospital Council committee and staff.

Library Service

The library serves the staff and the students of the University program in hospital administration as a source of reference material. This service is also available to anyone in the hospital field by means of our mailing service commonly known as package library service. By requesting information on a specific topic, a comprehensive file (or package) of pertinent material may be obtained through the mail on loan from our library. No charge is made for this service. It is interesting to note that in 1947 a total of 78 packages, 18 bulletins and pamphlets, and 9 books were thus borrowed. In 1952, these totals had risen to 252 packages, 72 bulletins and pamphlets, and 64 books. These latest figures are already almost equalled in the first 3½ months of 1953. I am indeed sorry to report that Miss Edith Brownlee, who has seen such yeoman service as our librarian over the past few years, is leaving us to return to England. She will leave behind her a large position to fill so that the library service may be continued.

Accreditation

Much has been, and will be, said

(Concluded on page 54)

Business Manager Reports

Charles A. Edwards

THE ADVERTISING office is very pleased to be in a position to report that the year 1952 was the best in our history, in amount of advertising space sold, and in gross dollar volume. Although the journal must maintain substantial reserves and working capital, the surplus for 1952 has allowed these figures to remain within the margins of prudent operation. At the same time, it has been possible to give assistance to the Council in offsetting secretarial expenses. A very substantial net journal profit was, therefore, placed to the credit of the Canadian Hospital Council.

This report is particularly gratifying in view of the mounting costs of publishing. Recent figures published show that none of the magazine publishers in the United States earned as much as 6 per cent on their gross business in 1952. Our net, in 1952, was almost 8 per cent.

The Canadian Hospital, you will see, has developed into a very valuable property, and it will interest those of you who have not had a long association with the Council to learn that the Canadian Hospital Council has not had to invest a single dollar either to acquire the journal or to finance its operations at any time.

More important to us, however, is the investment of the time and talents of those leaders in the field of hospital service who serve on the executive of the Council, our extremely capable secretarial and editorial staffs, and many, many others who respond to our requests for articles and information which we require from time to time. The journal is, therefore, not only a first-class financial asset, but equally valuable as a medium which assists the Council in its continuing efforts to improve hospital care and plays a part in the educational program of the Council, and as a forum for the exchange of views and experiences in the broad field of hospital service.

A long needed project which we embarked upon early in the year is the *Canadian Hospital Directory*, the first annual issue of which is just being mailed. Briefly, this has involved a great deal of extra time on the part of many on the staff. We are happy to report that, while it has proved expensive to produce the first issue, due to the large number of listings in various categories, the direct expense to the Council in providing a complimentary copy to every hospital in Canada will be met by advertising revenue. If sufficient additional copies are sold to individual subscribers and hospitals a small profit may be realized.

The *Directory* should prove very valuable to our readers and advertisers in the years ahead, and may also become a worthwhile financial asset of the Council.

The foregoing rather optimistic report should not indicate that we can become complacent and take for granted the continued growth of the journal. Up to the present time this year we have had cancellations or reductions in advertising space equivalent to nearly the average volume of advertising in one and a half issues of the magazine. We must, therefore, be continually on the alert to develop new accounts to replace these cancellations. Incidentally, advertisers cancel their advertising for various reasons. They may decide to use a different type of advertising medium, such as direct mail, catalogue, or so on. Or they may find it advisable to concentrate on markets other than the hospital field. They also may be disappointed in the number of direct enquiries they receive as a result of their advertising in *The Canadian Hospital*. We find that comparatively few readers write to advertisers and refer to *The Canadian Hospital*.

In closing this report, I wish to affirm my sincere appreciation of the splendid co-operation I have received from all those with whom it has been my privilege to work in the production of *The Canadian Hospital*. I am deeply gratified that it has been my good fortune to be identified with such a rewarding vocation as hospital service.

* * * * *

Résumé des Rapports

Murray Ross

C'est à moi que revient, le devoir et le plaisir de vous présenter un bref résumé du rapport de M. le docteur Swanson qui vient de vous décrire les principales activités du Conseil des Hôpitaux du Canada pendant les deux dernières années. Il a indiqué que beaucoup d'activités du Conseil seront décrites par d'autres conférenciers et que par conséquent son rapport est un bref résumé, une vue d'ensemble. Je profiterai aussi de l'occasion pour vous résumer brièvement ce que M. Charles Edwards a dit au sujet du programme de la revue hospitalière nationale.

Mais d'abord, permettez-moi vous dire un mot au sujet du changement survenu dans le personnel du secrétariat du Conseil auquel M. Le Président a déjà fait allusion. Comme vous le savez tous, M. le docteur Bradley a apporté à la direction du Conseil l'avantage de sa grande habileté. Nous regrettons qu'il ne soit plus parmi nous au bureau du Conseil. Cependant, la présence à cette réunion du docteur Bradley et du docteur Agnew semble bien suggérer que les anciens secrétaires exécutifs ne perdent pas facilement leur intérêt dans les affaires hospitalières et dans celles du Conseil.

Je suis très heureux et même rassuré de pouvoir vous dire, que vous avez trouvé en la personne du docteur Swanson un successeur distingué. Notre association avec lui pendant ces quelques derniers mois, nous fait envisager avec confiance la direction future du Conseil.

Dans le rapport qu'il vient de vous présenter, M. le docteur Swanson a dit qu'une des réussites importantes du Conseil depuis deux ans a été la préparation et la diffusion du *Manuel de la Comptabilité des Hôpitaux du Canada*. Le besoin d'un tel manuel définissant les principes et règlements pour la comptabilité et la statistique des hôpitaux Canadiens, se faisait sentir depuis longtemps. Déjà en 1935 le Comité de la Comptabilité et de la Statistique recommendait la préparation d'un tel manuel. Enfin le travail a été accompli et le manuel est

(Suite à la page 54)

Canadian Hospital Council Adopts New Name

Jessie Fraser

IN THE course of the 12th biennial meeting of the Canadian Hospital Council, held at the Chateau Laurier in Ottawa, May 18th to 20th, it was decided to change the name by which the "parliament" of the hospital field has been known since its inception in 1931. Application has been made to the Secretary of State to have the name read "Canadian Hospital Association—Association des Hôpitaux du Canada". No change in the functions of the national organization is implied in the new title. The step was taken because delegates were of the opinion that the word "association" indicated more clearly than the term "council" the responsibilities of the national body—especially to those outside the Canadian hospital field. Much as we may deplore abbreviations, they are occasionally unavoidable for reasons of space and the public press has already referred to the Canadian Hospital Association as the "C.H.A. (formerly C.H.C.)".

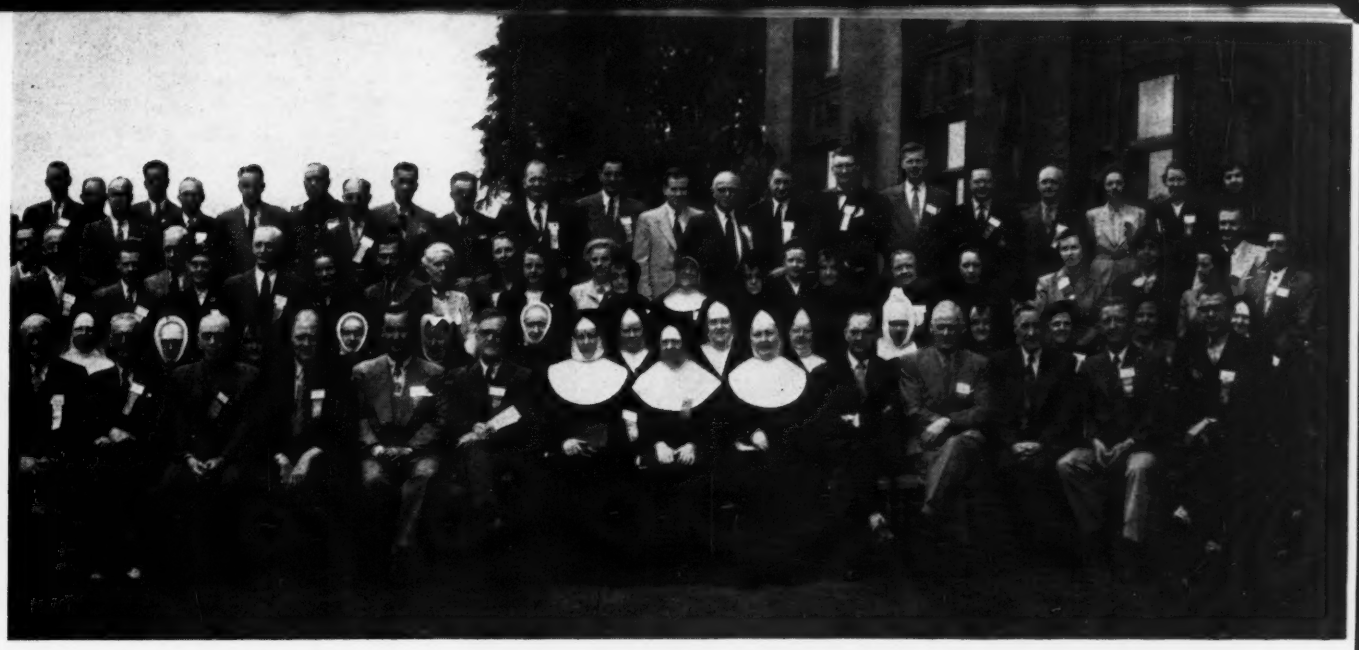
For three days prior to the general sessions, which opened Monday, May 18th, the board of directors convened and committee meetings were held. Beginning Monday, certain sessions were designated as Assembly Meetings so that delegates could carry through the business in hand as expeditiously as possible. General or open sessions were marked by fewer addresses than is usual and more panel discussion periods were provided. The agenda so arranged met with the enthusiastic approval of delegates.

At the opening session the assembly accepted into active membership in the national organization the Comité des Hôpitaux du Québec. Associate membership was extended to the Canadian Council of Blue Cross Plans; to the Canadian Dietetic Association; and to the National Council of Women's Hospital Auxiliaries.

Accreditation

Perhaps the most important and certainly the most debatable subject among the agenda of this meeting was the problem of the accreditation of Canadian Hospitals with respect to the quality of care provided to patients. (The word *accreditation* means *authoritatively sanctioned* and in itself gives rise to the question: by whom?) As is well-known, for over 30 years the American College of Surgeons had carried out a program of accreditation for hospitals in the United States and Canada. When that program came to an end on January 1st, 1953, a Joint Commission, representing several interested organizations in the United States, and including the Canadian Medical Association, began to carry on this work. Meanwhile a Canadian Commission, with members appointed by the C.M.A. and the C.H.C., was set up to study the possibility of (a) setting up a purely Canadian program or (b) some compromise arrangement by which Canadian hospitals might be inspected by Canadian appointees in co-operation with the Joint Commission. After long study, the Canadian Commission, in view of the high cost of instituting an independent program, presented a compromise proposal to active members of the Canadian Hospital Council and delegates came to Ottawa prepared to discuss the issue. For details of the six-point proposal see page 37.

Delegates were unanimous in declaring a Canadian program to be desirable but opinion varied as to its feasibility and even the possibility of immediate participation in any alternative plan. Discussion was rapid and so avid were delegates for full information that the chairman, Dr. O. C. Trainor, was hard put to it to see that everyone who rose had his or her chance to speak and in proper turn. A morning session having been devoted to this subject, the assembly met again at 7.30 that evening to continue its analysis — and that meeting lasted until ten minutes after midnight! Eloquence heightened with the waning hours but tension was relieved by



touches of humour and a true sense of fellowship was apparent, regardless of differences of opinion. Certain delegates indicated the need to confer again with their own directors before casting a final vote. However, a standing vote of all delegates indicated majority approval of each point in the recommended program, following minor changes in wording. Subsequent to the voting on the individual points, there was a unanimous vote to support the majority decision.

Account of C.H.C. Activities

In his presidential address, Dr. O. C. Trainor, reviewed the expanding role of the national office and stressed the need for a more even distribution among *all* hospitals of the cost of supporting this service by which *all* hospitals benefit. His explicit recommendations were a challenge to the field (see page 31) and these were incorporated in a resolution (page 62).

The treasurer's report, read by Dr. A. Lorne C. Gilday, reaffirmed the policy that the cost of maintaining secretarial activities should be a direct charge against member organizations. Fortunately, he said, we have had the support of the Sun Life Assurance Company. Since 1946, total income from all contributions for secretarial work has increased from $24,347.63 to $32,498—but unfortunately expenses have increased in greater proportion —so that we show a deficit for each of the past three years. *The Canadian Hospital* has, however, shown an average surplus of $3,052 for each of the past seven years and this, less the deficits, has enabled us to build up a reserve or "working capital" without which we would be unable to function. "We wish," continued the treasurer, "to express our full appreciation of the splendid increase in contributions from the various provinces" — these contributions now being more equitably distributed among the provinces.

The reports presented by Dr. A. L. Swanson, Executive Secretary, and Charles Edwards, Business Manager, were summarized as one in the French language by Murray W. Ross, Associate Secretary (see page 43).

Dr. Harvey Agnew, chairman of the Committee on Education, reviewed the origins, financing, and progress made in the development of two extension courses, one in hospital organization and management and a second, in its initial stage, for medical record librarians. He introduced Donald M. MacIntyre, secretary of the committee, who spoke briefly on the first course, now in its second year. Mr. MacIntyre observed that the 99 students enrolled in the two years represented all provinces and that of this original number only eight have been dropped. Enthusiasm among students is constantly apparent, he said. While the part played by the C.H.C. and the Kellogg Foundation in

". . . the tribute of a grateful government and a grateful people."

They came

from the east . . . .

Among the many sisters present at the C.H.C. 12th biennial meeting were: Mother Ignatius, Antigonish, N.S.; Sister Maura, St. Michael's, Toronto, sitting in the front row; and standing, l. to r., Sister Cazabon, Windsor, Ont.; Sister Paul of the Cross, Antigonish; and Sister Mary Evangeline, Pembroke, Ont.

Chatting together are, left to right: Helen McArthur, and Eugenie Stuart, Toronto; Dr. G. E. Wride, Ottawa; L. F. Detwiller, Victoria; and Father Leahy, Vancouver.

Front row, left to right: G. H. Shaw, Montreal, J. B. Mickie, Sainte Anne de Bellevue, P.Q.; Roland Levert, Montreal; back row: R. G. Goodman, Winnipeg; A. H. Westbury, Montreal; Leonard Wilson, Drumheller, Alta.; Dr. R. J. Dolan, Fredericton, N.B.; Walter W. B. Dick, Moncton; G. W. Myers, Regina.

and they came

from the west

The biennial meeting in action.

A mingling of east and west, left to right: Eugene Bourassa, Regina Grey Nuns' Hospital, Regina; Paul Shannon, Royal Victoria, Montreal; Dr. C. M. Bethune, Victoria General, Halifax; and Dr. Carl R. Trask, Saint John General, Saint John, N.B.

All westerners, left to right: Sister Helen, Barrhead, Alta.; Sister M. Beatrice, Lethbridge, Alta.; back row, Judge Nelles V. Buchanan, Edmonton; A. H. J. Swencisky, Vancouver; Donald M. Cox, Victoria.

Mrs. Agnew shares his pleasure.

initiating the course cannot be overemphasized, Mr. MacIntyre stressed that a major portion of the credit for its success can be attributed to the splendid spirit of co-operation accorded this project by individuals, associations, and governments in all parts of Canada. There is, he said, a working organization of over 100 people "who have given unsparingly of their time and effort during the formative stages of the program and are continuing to participate by assisting with the revision of lesson material, the marking of assignment papers, and lecturing at summer sessions." "Those of us," he said, "who are concerned with the details of operating this program are sincerely appreciative of this splendid support and, on their behalf, I wish to express our thanks."

Doris McPherson of headquarters' staff outlined the curriculum being prepared for the course for medical record librarians; and Andrew Pattullo, speaking for the W. K. Kellogg Foundation, referred to the two extension courses as "dynamic" because they train people to perform their work more satisfactorily and prepare them for promotion. He noted also that these courses are "unique in the world".

Without Uniformity, no Comparability

In his report to the assembly, Walter Dick, Chairman of the C.H.C. Committee on Accounting and Statistics, spoke first of the new statistical reporting schedules introduced by the Dominion Bureau of Statistics in 1952. "You are, I am sure," he said, "amazed at the ease and speed with which these forms may be completed—*i.e.*, after you have read the *Canadian Hospital Accounting Manual*". Mr. Dick emphasized the importance of the new forms in the words "without uniformity there can be no comparability and without the latter there can be no proper evaluation of results". The committee made three recommendations to the Assembly:

1. That accounting and statistical institutes be encouraged under the sponsorship of provincial and area hospital associations with the assistance of the Council.

2. That the Council study the possibilities of developing an extension course for business office staff aimed primarily at accounting and statistics.

3. That the Council make provision for arranging at least one annual meeting of the members of the Committee on Accounting and Statistics. Furthermore, that more frequent meetings be held throughout the year for an executive group of this committee.

Speaking for the Dominion Bureau of Statistics, Institutions Branch, Bernard R. Blishen declared earnestly that statistics were not collected for the Dominion government *but* for the use of the public. He pointed out that Canada now has a national system of hospital accounting which, he said, is unique anywhere.

Stephens Memorial Award

A very pleasant highlight of this 12th biennial meeting was the Association dinner at which the George Findlay Stephens Memorial Award was formally presented to Dr. Harvey Agnew by the President, Dr. O. C. Trainor (see *The Canadian Hospital* April, page 41). The beautifullly engraved citation was read by Dr. A. L. Swanson. In acknowledging this honour Dr. Agnew said in part:

"Many, many people have contributed, times without number, to the advancement of our hospitals, to their greater efficiency and economy in operation and to the quality and extent of the services which they render to patients and to those who care for them; many have made notable contributions to the advancement of hospitals as educational and research centres. To have the privilege of being numbered among those whom one's fellows have selected for the George Findlay Stephens Memorial Award is an honour which is appreciated much more deeply than I can express."

Dr. Agnew then delivered a reminiscent and entertaining address entitled "After Twenty-five Years" in which he paid tribute to the "giants of the past" who paved the way toward the health services which we enjoy today.

Civil Defence

Dr. K. C. Charron, Principal Medical Officer, Civil Defence Health Planning Group, Ottawa, reviewed developments, trends, and needs, in hospital disaster planning. Because a major peacetime or wartime catastrophe would place an overwhelming load on existing hospital resources, he said, the value of a well-organized disaster plan cannot be overestimated and every hospital should prepare one. It should be a *written* plan and available to all key staff at all times. The speaker outlined certain general principles of defence planning but pointed out that "it is up to the individual hospital to work out detailed arrangements essential in the handling of large-scale disasters". He stressed the need for flexible planning and the importance of basic uniformity across the country.

On Monday evening a demonstration by members of the Civil Defence Health Planning Group lacked in realism only the final destructive force of the A-bomb. On stage was a backdrop of the target town with realistic smoking ruins, as it would be a few minutes after an explosion. The team, under the direction of Evelyn Pepper, nursing consultant, showed how a damaged school-room might be pre-

"Until the day's out and the labour done"

At the close of the C.H.A. meeting, the new board of directors met to continue and initiate association business. Seen here are, left to right, front row: Dr. O. C. Trainor, Winnipeg, (past president); Father H. L. Bertrand, Montreal, (1st vice-president); Dr. A. C. McGugan, Edmonton, president; Dr. Douglas Piercey, Ottawa, (2nd vice-president); Rev. Mother Ignatius, Antigonish, N.S. Back row, left to right: Murray W. Ross, Toronto, (Associate Secretary); Dr. D. F. W. Porter, Moncton, N.B.; Dr. Gilbert Turner, Montreal; John Smith, Yorkton, Sask.; Dr. Lorne Gilday, Montreal, (Treasurer); Percy Ward, Vancouver; and Dr. A. L. Swanson, Toronto, (Executive Secretary). Not present were: A. J. Swanson, and Rev. Father John Fullerton, both of Toronto.

pared as a casualty clearing station, and then casualties of the various types to be expected were brought in. The demonstration underlined the need for preparedness and showed how a trained civil defence team can save lives and ease suffering.

Trends in Financing Hospital Care

Under this general heading, D. W. Ogilvie, Executive Director, Ontario Plan for Hospital Care, discussed the development, present coverage, and future possibilities of existing prepayment plans. The speaker noted that 6,000,000 Canadians are voluntarily insured against the cost of hospital care and that the hospital's source of income today comes very largely from payments made by various third party insurers. It can be assumed, he said, that this major economic development is one which is here to stay. Mr. Ogilvie pointed out that the problem of covering the cost of hospital care for indigents could be solved through co-operation between voluntary plans and government at provincial and municipal levels.

Speaking on behalf of the provinces which have government hospital insurance plans, Dr. F. B. Roth, Deputy Minister, Saskatchewan Department of Public Health, Regina, and L. F. Detwiller, Commissioner, British Columbia Hospital Insurance Service, Victoria, commented upon their respective systems.

Dr. Roth emphasized that the hospitals of Saskatchewan were responsible for their own operation and that the rate of payment for hospital care was negotiated with the hospitals. Since the inception of the plan, he said, the ratio of beds per 1,000 of population had increased significantly, *i.e.*, from 6.7 per 1,000 to 7.7. He pointed out, too, that because depreciation was accepted as part of operating costs, hospitals were encouraged to offer new services.

Concerning the B.C.H.I.S., Mr. Detwiller stated that while "it has been tossed about in the choppy seas of controversy for four years, . . . (the plan) has now emerged into the calmer waters of what appears to be success". Today the B.C.H.I.S. "receives the undisputed support of the hospitals, the medical profession, and other associated groups, the government and the people."

Final speaker on this panel was Malcolm G. Taylor, Ph.D., Assistant Professor of Political Economy, University of Toronto, who presented a thought-provoking treatise on the broad subject "Government Aid to Hospitals in Canada". Dr. Taylor warned that "in our discussions of what government should or should not do, we must be careful that we do not destroy faith in our democratic institutions". In a democracy, he said, government is no third party. The government is the people. Criticism is essential but it must be constructive. A second point which the speaker stressed, in connection with government aid, was the obligation of government to respect the democratic process. Solutions to the problems which confront us must be worked out in a spirit of partnership, he said. Both voluntary agencies and government must be sensitive of and responsive to the people's needs and the people's voice—was his conclusion.

National Health Program

Reviewing five years of health progress in Canada, the Hon. Paul Martin, Minister of National Health and Welfare, observed that since the beginning of the national program in 1948 Canada has increased its total public hospital facilities by at least one third. Nearly 40 per cent of the total grants available were used for that purpose. He then reiterated his recent announcement in Parliament that additional federal grants—totalling $42,000,000 over the next five years—are now available to widen the scope of this program. Mr. Martin described in some detail the manner in which the new grants may be used (to be published later) and finally paid tribute to the hospitals of this country in the following words:

"In the forward sweep of humanity in Canada, our hospitals and all who

(Continued on page 62)

Food and Its Service

Sponsored by The Canadian Dietetic Association

Emergency Feeding in Civil Defence

Edith M. Wark,
Chief Dietitian,
Toronto Western Hospital,
Toronto, Ontario

CIVIL DEFENCE has, to many of us, been merely something to which we see occasional reference in the newspaper or on the radio but not anything which need give us concern. To some people across Canada it is a serious matter and to many others a full-time job. For the first time it in the history of Canada, it is felt that in time of war we are liable to attack. The growing importance of Canada and of Canadian industries to the world makes our country a threat to any enemy and, therefore, one to be crippled if war should come.

What is meant by "Civil Defence"? It is the preparation of oneself for self-preservation in time of disaster. Self-help and mutual help should be the responsibility of each and every person in Canada.

Plans for civil defence were commenced several years ago with the federal government as the over-all co-ordinator. Expansion of these plans has been made down through provincial governments to municipal or local governments in an effort to gain uniformity of planning across Canada.

The Civil Defence Welfare Planning Group of the Department of National Health and Welfare was formed to advise the Federal Civil Defence Co-ordinator in all matters pertaining to the well-being of people in time of disaster. This group has initiated plans at the federal level and developed an over-all pattern which it is hoped will serve as a guide to provincial and local organizers. Local welfare service is manifold, prepared to provide food, clothing, and shelter and to give information, advice, and rehabilitation aid to those made homeless.

Emergency feeding is one very important part of the civil defence organization and, in the past two years, a vast amount of thought and work has gone into plans for feeding not hundreds but thousands of people if disaster should strike. The C.D.A. felt it a privilege and an honour to have been called in on one of the initial workshops set up for the purpose of compiling a pamphlet, *Emergency Feeding in Civil Defence.* Since that time a Canadian Dietetic Association Committee has been at the service of the Department of National Health and Welfare and has given assistance in the preparation both of a basic emergency feeding pamphlet anf of a second manual dealing with the technical aspects of the same subjects, including recipes, menus, food quantity tables, equipment, and kitchen and servery organization. Work is continuing with the drawing-up of a pamphlet on the improvisation of stoves, cooking utensils and food coolers, with complete instructions in the preparation and use of each.

Within Welfare Services, emergency feeding has been organized from two aspects—operational (the preparation and serving of food) and administrative (the procurement of food supplies, equipment, fuel, and water). Operational is under the direction of the chief of emergency feeding, the administrative under the chief of the supply section. Each welfare centre would have supervisors for both of these operations, directly responsible to the manager of the centre. The supervisor would, in turn, have volunteer workers in all the necessary categories — cooks, helpers, dishwashers, and truck drivers, to mention but a few.

Feeding in time of disaster has been divided into two main headings:

1. *Short-term food service.* It is estimated that this service would continue for approximately four days, including the day of disaster. The importance of food, particularly of a hot beverage, as soon as possible after disaster cannot be over-estimated in its effect on morale and in alleviating shock. Infants under two years of age and casualties are given priority over other groups.

2. *Long-term food and nutrition service.* While civil defence is concerned primarily with temporary feeding, plans must be made for mass feeding of evacuees at assembly areas and en route to welfare centres. This may be necessary for a considerable period.

Immediately will come to your minds the thought: "has the nutritional requirement of these feedings been taken into consideration?" Although recognizing the value of nutrition, I must say that nutritional requirements are of no concern in the immediate emergency period. Give the people something hot to eat and drink during those first four hectic days and let the vitamins look after themselves. Special groups though, such as infants and casualties, would have to be watched more closely. After the initial shock period, however, care must be taken to ensure that the populace, generally, maintains a sufficiently high standard of nutrition.

The Emergency Feeding Section of Civil Defence is the place where you, as dietitians, trained in the feeding of large groups, can make a valuable contribution to your country. Should there be an attack or should there be a major peacetime disaster, many of you engaged in hospital work or in industrial feeding would be so fully occupied that any volunteer work would be out of the question. Now, though, while civil defence planning is under way, your help may prove

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Reprinted from "The Journal" of the Canadian Dietetic Association, March, 1953.

The Coryllos Thoracoscope

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600A as illustrated with footswitch and cautery-light transformer. The biopsy forceps illustrated in lid of case is an accessory instrument and is sold separately.

Biopsy Forceps, Cat. No. 389

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Executive Secretary's Report

(Concluded from page 42)

by others concerning our policy on accreditation. The executive staff has been close to the debate throughout and has had considerable to do in the dissemination of information and the compilation of opinion which has guided our directors in their deliberations. While much executive time has been consumed by this one matter, it is my considered opinion that such an important subject must be firmly and satisfactory thought out in order that the most effective decision may be reached for the good of all.

The Biennial Meeting

During the last many weeks of preparation, it has been forcibly drawn to my attention that this "parliament of the hospital field" is a major activity for the executive staff. Accustomed as we tend to be to look only for the material production of an organization, the intangible benefits of a great gathering such as this may easily be overlooked. This gathering together of representatives from all parts of Canada with visiting colleagues from the United States is a tremendous opportunity for all of us to learn, to compare notes, and to know each other better.

Other Services

In addition to the functions mentioned, your executive staff has many other claims upon its time. Through membership on various committees, hospitals are represented in rehabilitation planning, civil defence health planning, the Defence Medical and Dental Services Advisory Board, the Continuing Committee on Hospital Statistics, and the University teaching program in hospital administration. Several thousand miles are travelled annually to attend hospital meetings and institutes and to assist wherever possible. Assistance with National Hospital Day and the production of bulletins and memos are other activities that should be noted.

Conclusion

The work of the Council executive office has been expanded to the point where, to render the service we desire, our office space, finances, and staff are strained to the limit. While we must now pause briefly, in order to consolidate our recent advances, no organization can stand still. It either moves onward or slips back to mediocrity. Working as I am in the shadow of two eminent predecessors who, with your backing and encouragement, constantly moulded and built for better things, I find myself forced to look searchingly ahead in order to see clearly the still broader horizons. It would seem to me that what has been planned and executed so well in the past must be encouraged to flourish. The thought that eventually I might presume to expand these services still further would be fruitless indeed had not Dr. Harvey Agnew and Dr. L. O. Bradley left behind them a group of people, trained and inspired by their leadership, who have carried on in the highest tradition. As the offices have grown progressively, the importance of any one individual has become less and less in relation to the total effort. With this thought in mind I wish to close my report by thanking my staff for their loyal support which has made the Council work possible, and by requesting the same fine backing from our member associations and conferences which has characterized the past many years of Canadian Hospital Council service.

Résumé des Rapports

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devenu une réalité.

Nous tenons à remercier à cet égard le Ministère de la Santé Nationale et du Bien-être Social, et la Ministère de la Santé publique de l'Ontario, qui ont fourni la plus grande partie des fonds nécessaires provenant du programme des subventions pour la santé nationale.

Un des grands problèmes qui se sont élevés a été celui de la normalisation des hôpitaux. Cette question a été discutée à la dernière assemblée biennale après que nous avons appris que la Société Américaine des Chirurgiens n'allait pas poursuivre indépendamment son programme hospitalier.

Comme le docteur Swanson l'a déjà indiqué, un temps considérable sera consacré pendant cette réunion afin d'aboutir à une conclusion satisfaisante, à cet égard. Il en a parlé seulement parce que votre personnel et vos directeurs ont consacré beaucoup de temps et d'efforts aux discussions que ont eu lieu. Les membres du secrétariat du Conseil ont assisté aux réunions annuelles de chaque association et à certaines des réunions des Conférences. Il est toujours agréable de visiter divers coins de notre pays, de revoir de vieux amis, et de faire de nouvelles connaissances dans le domaine hospitalier. De cette façon, on peut se tenir au courant des événements qui nous intéressent tous.

M. Edwards vous a parlé de votre revue hospitalière nationale, — la "Canadian Hospital". La préparation et la publication de cette revue représentent une part importante de nos activités. C'est un organe pour l'échange d'idées et d'informations ayant rapport aux sujets hospitaliers. Et c'est aussi une entreprise assez rare dans le domaine hospitalier puisque ce service pourvoit non seulement à ses propres frais mais s'en tire aussi avec profit. Des fonds de réserves constituant une marge de sécurité, ont été établis pour parer à l'imprévu dans la publication de la revue. Tout surplus réalisé dorénavant pourra contribuer à équilibrer le budget du programme croissant, des autres activités du Conseil.

M. Edwards en sa capacité de chef de la publicité, a rapporté que c'est en 1952 que la publicité a atteint son niveau le plus élevé dans toute l'histoire de la revue. La revue est devenue une propriété précieuse autant qu'utile. Le Conseil n'a pas dû débourser de fonds pour en prendre la succession ni pour en assurer le développement. Je devrais peut-être ajouter que le mérite de la situation financière satisfaisante de la revue, revient en grande partie, à la sage direction de M. Edwards.

Nous réservons chaque mois une partie de la revue à l'usage de la langue française. Malheureusement trop peu d'articles écrits en français nous parviennent. Nous espérons que vous vous intéresserez tous à la préparation d'articles hospitaliers rédigés en français et destinés à paraître dans la revue, et que vous encouragerez d'autres à suivre votre exemple. C'est le moyen idéal de partager avec vos collègues, vos connaissances.

M. le docteur Swanson et M. Edwards on fait allusion à la publication de l'annuaire des hôpitaux Canadiens. Le premier tirage de tout annuaire est une entreprise à la fois difficile et coûteuse. Toutefois, nous sommes heureux de pouvoir déclarer que les dépenses directes nécessaires pour fournir un exemplaire à chaque hôpital, seront couvertes par le revenue provenant de la vente des annonces. Le vente d'exemplaires additionnelles

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Résumé des Rapports

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aboutira peut-être à un profit modeste. Il se peut bien qu'à l'avenir, l'annuaire devienne une publication de valeur.

M. le docteur Swanson a remarqué que les activités du Conseil deviennent de plus en plus nombreuses entre les réunions biennales, et que souvent d'importantes décisions doivent être prises par les directeurs et le personnel exécutif. Il y a en effet un long intervalle de deux ans entre les réunions de cette Assemblée qui formule les lignes de conduite.

En 1949 le nombre du personnel au bureau du Conseil se montait à onze, en 1951 à quinze et aujourd' hui nous sommes vingt-et-un. Sur ce nombre, six travaillent exclusivement à préparation de la revue, six au cours d'extension, quatre font partie du secrétariat, et les autres cinq répartissent leur temps entre le secrétariat, et les autres départments.

M. le docteur Swanson et M. Edwards ont exprimé leur reconnaissances de l'assistance et de la coopération apportées par leurs collègues, et par tous les groupes dont vous êtes ici les représentants aujourd'hui. Permettez-moi de me joindre à eux et de vous exprimer mes remerciements personnels.

Continuing Education

The significance of continuing education is that it rescues men and women from slave-like insignificance, from the sense of being powerless and alone.

Too many, alas!, rely wholly upon science, the marvel of this age. Science can not, by itself, solve our major human problems. It can not impose upon people the co-operative, give-and-take relations we should like to see between individuals and between nations. What we need, in continuing education, is ennoblement of individuals through philosophy, the arts, religion —what we refer to as the "humanities".

Continuing education will, as a matter of course, give us a sense of creativeness and a knowledge of our purpose as citizens in a political society. It demands our fullest possible intellectual development; and that means awareness of our personal responsibility in the life of the world and in our fellowship with the whole of mankind. —*Royal Bank of Canada Monthly Letter*

For the Small Kitchen

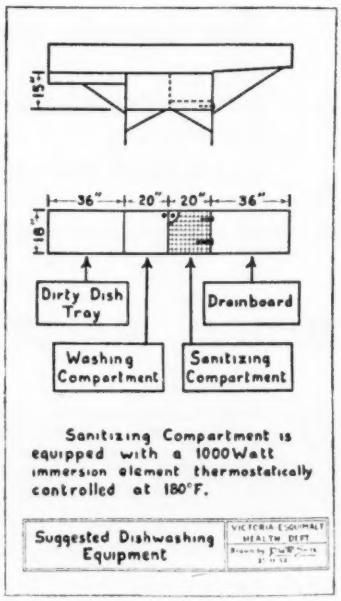
Easier Dishwashing Techniques

D. W. R. Smith, C.S.I. (C),
Victoria-Esquimalt Health Dept., Victoria, B.C.

DURING the past ten years, much research had been undertaken to provide better dishwashing techniques for institutions serving food to the public and many excellent articles dealing with laboratory findings and the results of controlled experiments have been published. The observations, suggestions, and conclusions contained in this article are made from the standpoint of a sanitary inspector working in the field.

In the main, dishwashing in larger institutions does not present a serious problem, as in most cases they are equipped with dishwashing machines which are capable of doing satisfactory washing and sanitizing. The cost of providing such equipment in smaller institutions and coffee shops is too high to be economically sound and, as a result, hand dishwashing is the only practical method. These establishments are usually equipped with two- or, in some cases, three-compartment sinks; and most of them rely on a chemical rinse for sanitizing the dishes. It is not impossible to produce properly sanitized utensils by the use of a chemical rinse. Undoubtedly, in a laboratory or under supervised experimental conditions excellent results can be obtained but under practical operating conditions the human factor involved makes this method unreliable. Every possible excuse for not using the chemicals has been offered. Such excuses as " it leaves an odour on the dishes", "It is too hard on the hands", "my supply ran out yesterday and the order has not been filled yet" are all too common.

In cases where the management has taken great care to impress upon the dishwasher the necessity of using the chemical, the sanitizing compound is only added each time the rinse compartment is filled and, while the first batch of dishes through the rinse may receive satisfactory treatment, the sanitizing agent is usually completely exhausted before the rinse water is changed so that the last lot of dishes through the rinse receive little, if any, bactericidal treatment. The most undesirable feature of chemical sanitizing, however, is the necessity of towel-drying the utensils after they have been sanitized. The temperature of the rinse water is rarely higher than 120° F. and air-drying of utensils, which have been immersed in water at this temperature, is too lengthy a process to be practical.



New Method

Some two years ago, the Victoria-Esquimalt Health Department set out to devise some method of dishwashing and sanitizing which could be installed at a cost that would make it practical for smaller operations and, at the same time, make the work of the dishwasher easier if proper techniques were followed. With the co-operation of certain proprietors, who were prepared to make the expenditures required to convert an ordinary two-compartment sink to a unit which provides heat sterilization, we began the experiment. The diagram shows specifications for the unit which we are now recommending for use in establishments where hand dishwashing is used.

The sanitizing compartment is equipped with a 1000-watt immersion element connected through a thermostat set at 180°F. When installing this equipment, the thermostat must be placed far enough away from the element so that it will not be affected by the pocket of high-temperature water surrounding the element. The element and thermostat are protected by a false bottom approximately three inches above the actual bottom of the sink. The false bottom is constructed of heavy-gauge wire mesh or perforated heavy-gauge sheet metal supported by legs or lugs on the sides of the sink. It is desirable to have the false bottom removable for cleaning purposes.

If the sanitizing compartment is built according to the specifications in the diagram, the 1000-watt element and thermostat setting of 180°F. will give satisfactory results. Where the size of the sanitizing compartment is larger than specified in the diagram, a larger element is required and, in most cases, it is necessary to increase the thermostat setting in order to maintain a temperature of 170°F. after the dishes are inserted. It is necessary to have a cut-off switch installed so that the units can be turned on and off as desired. A small pilot light, preferably on the wall above the sanitizing compartment, which is lit when the element is on, has been found most useful to remind the operator that the sanitizing compartment must not be drained until the element has been turned off. These elements are designed to operate in water and will burn out rapidly if left on after the

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Reprinted from the "Canadian Journal of Public Health", March, 1953

Accreditation Service

(Concluded from page 38)

for consideration in a compromise proposal:

1. THAT the Canadian Commission on Hospital Accreditation reaffirms the previous recommendation that an exclusively Canadian program of hospital accreditation is desirable;

2. THAT it is now recognized that the institution of such a program is not feasible at present, owing to inability to secure sufficient financing;

3. THAT it is therefore agreed that co-operation with the Joint Commission on Hospital Accreditation offers the best prospect for the operation of a hospital survey program in Canada;

4. THAT it is agreed the Canadian Hospital Council shall seek direct representation on the Joint Commission;

5. THAT the Canadian Commission recommends to its constituent organizations participation in the survey of the Canadian hospitals through the financing and employment of an additional inspector by the Canadian Commission, on the same basis as those presently employed on behalf of the Joint Commisssion;

6. THAT it is recommended to the constituent organizations that the Canadian Commission on Hospital Accreditation continue to function on behalf of Canadian interests.

Items 3, 4 and 5 were fully discussed at the joint meeting and Dr. Crosby made the following observations:

Re point 3—Dr. Crosby reiterated the desire of the Joint Commission to co-operate to the fullest extent with Canadian organizations.

Re point 4—The matter of direct representation for the C.H.C. on the Joint Commission would have to be referred to the Joint Commission for decision when application is made by the C.H.C.

Re point 5—Dr. Crosby could see no objection to the Canadian Commission engaging an additional inspector to supplement hospital survey work in Canada whether or not the C.H.C. pays for a seat on the Joint Commission. Such inspection would report all findings to the Joint Commission for determination of accreditation standing.

There were thus three courses of action open to the member organizations of the Canadian Commission on Hospital Accreditation: (1) acceptance of the Joint Commission program as it now stands; (2) a purely Canadian program; (3) a compromise between 1 and 2 as outlined in the foregoing six points.

Compromise Proposal

Due to the lack of government financial aid, the Canadian Commission recommended to its members the compromise proposal. Although the expenditure of funds by member organizations will be of the same order as for a purely Canadian program, there are certain advantages in the compromise:

(a) an additional inspector could be provided in Canada, thus almost doubling the services presently available;

(b) the investment would be in an established organization and therefore on a sounder financial basis;

(c) complete co-operation between the various participating organizations, both Canadian and American, should be ensured;

(d) through Canadian members on the Joint Commission as a Canadian committee group receiving advice from a broadly representative Canadian Commission, the opinion of all sections of the country on accreditation matters should be well represented;

(e) reciprocity of hospital, intern, and other forms of approval, should be facilitated;

(f) should Canada at any time desire to establish a completely independent program, we have been assured by the Joint Commission representatives that there would be no obstacle and that we would have their complete co-operation.

Estimated Cost of Compromise Proposals to Canadian Hospitals

	Minimum		Maximum
One seat on the Joint Commission*			
Estimated cost of one inspector—salary and travelling expense 15,000-$20,000 per year divided between member organizations of the Canadian Commission on basis of 12 seats: 5 hospital seats would cost	$6,250	or	$ 8,333
	$9,750		$11,833

**This figure represents the cost of obtaining one seat. It would be replaced by an annual assessment to cover central office expenses. The annual assessment is variable and presently approximates $4,500 per year.*

* * * *

Approximate Costs

Estimated minimum and maximum figures on the cost of compromise proposals to Canadian hospitals are listed above.

To these figures would be added the cost of meetings of the Canadian Commission. These meetings would be relatively infrequent—once or twice per year and would cost hospitals, for their five representatives, possibly $700 per meeting. The minimum cost for the compromise proposal would therefore be in the neighbourhood of $10,450 per annum. The maximum cost would be $13,233 per annum. These figures, although only approximations, will give a general idea of the cost

Action Taken at Biennial Meeting

The whole topic of accreditation was thoroughly discussed during the recent Biennial Meeting of the Canadian Hospital Council at Ottawa. The original six points referred to above were adopted with certain necessary changes. They appear in their final form on page 37.

A Registry for Pathologists

The Canadian Association of Pathologists are operating a registry which will serve hospitals seeking pathologists and pathologists who wish to find employment in a hospital. Further information concerning this registry can be obtained from D. W. Penner, M.D., Secretary-Treasurer of the Canadian Association of Pathologists, Winnipeg General Hospital, Winnipeg, Man.

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(Continued from page 50)

work within their walls have a proud and honoured place. I bring you the tribute of a grateful government and of a grateful people for your contribution to health progress and for your part in strengthening, by your service, our Canadian way of life."

The session then became an open discussion period with a panel of representatives from the Department of National Health and Welfare present to answer questions. These were: Dr. F. W. Jackson; Dr. G. E. Wride; Ray Carriere; and H. Gordon Hughes. Questions were showered upon them; and the replies were rapid, specific and very satisfactory.

Associate Members' Reports

In reporting for the Canadian Council of Blue Cross Plans, J. R. H. Robertson of Montreal stressed that "the price of survival of the private voluntary organization is not only eternal vigilance, but eternal efficiency, and eternal service—service at a price the people can pay and are willing to pay". Providing that service, he said is the purpose of Blue Cross which, as a non-profit, prepayment scheme, is helping 3,000,000 Canadians to help themselves. Brief summaries of the activities and status of the five Canadian plans were presented by: Dr. Angus McGugan for Alberta; Dr. O. C. Trainor for Manitoba; David Ogilvie for Ontario; and Roger Chartrand for Quebec.

Miss Grace Sharpe, Ottawa Civic Hospital, addressed the meeting on behalf of the Canadian Dietetic Association. Speaking in English and then in French, she presented in brief outline the history, membership, and activities of that association which has, as of last month, become an associate member of the Canadian Hospital Association.

Mrs. Gertrude Whiteside of Windsor, Ont., secretary-treasurer of the National Council of Women's Hospital Auxiliaries of Canada, reported the ratification by that Council of its proposed constitution and by-laws. Final ratification will be made by the provincial associations. She announced that, at their concurrent meeting, Mrs. J. Cecil McDougall of Montreal had been elected president, with Mrs. John Oliver of Edmonton, vice-president. The president was accorded the privilege of selecting a secretary and treasurer from her own province. Mrs. Oliver Rhynas who "has guided hospital auxiliaries for so many years" was named past president.*

Miss Pearl Stiver, recently appointed general secretary of the Canadian Nurses' Association, was introduced to the hospital field by the president of that organization, Miss Helen McArthur. In her report Miss Stiver explained that the C.N.A. is the federation of provincial nursing associations and its purpose is to coordinate the work of the provincial bodies. There is a total membership, she said, of 31,613. The national organization carries on a recruitment program, formulates nursing policies, and sponsors research projects in nursing. It is the duty of the head office, she said, to interpret nursing policies to nurses through their official journal and by other means to non-nursing groups. Miss Stiver indicated that the Canadian Nurses' Association is represented in the International Council of Nurses and also the World Health Organization. When the I.C.N. meets in Brazil in July, there will be altogether 21 Canadian representatives present, she said.

Third Party Payments

This session was a question-and-answer period with a large panel representing "third parties" and these gentlemen were subjected to rapid-fire interrogation. The panel included: Dr. Percy Moore, Director, Indian Health Services, D. N. H. and W.; Dr. W. P. Warner, Director General of Treatment Services, D.V.A.; W. W. Dawson, Director, Special Services—Hospitalization and Medical Aid for Indigent Immigrants (Federal-Provincial Agreements); Dr. H. D. Reid, Chief, Quarantine, Immigration Medical and Sick Mariners Services; Major H. C. Chadderton, National Secretary, Army Benevolent Fund; Air Commodore D. E. MacKell, Manager, Royal Canadian Air Force Benevolent Fund; Lieut. (S) H. McClymont, Secretary-Treasurer, Canadian Naval Service Benevolent Trust Fund; as well as D. W. Ogilvie, J. R. H. Robertson, and Roger Chartrand, representing Blue Cross.

As ever, the Indian Health Services Branch received its quota of complaints because in most provinces it does not pay the full cost of hospital service for Indian patients. To all of which Dr. Percy Moore patiently and firmly replied that the federal government had no legal obligation to provide medical care for the native population though it had assumed a moral one. One of the chief aims of his department, the speaker said, was to raise standards among the Indian and Eskimo population by public health measures in the hope that eventually they would be able to pay their own way. It was suggested that an effort be made to bring this segment of the population under a prepayment plan, such as Blue Cross. Concerning rates of payment to hospitals, Dr. Moore said that, like most municipalities, his department pays as much as it can.

Dr. Warner of the D.V.A. declared that his department was prepared to pay the full cost of service at all times; that many of their own hospitals were teaching institutions; and that he would like to see medical administration become a medical specialty under the Royal College of Physcians and Surgeons (C.).

The problem of indigent immigrants was thoroughly investigated since many hospitals have had difficulty in collecting accounts for these unfortunates. Apparently hospital people were not too well informed concerning the possible federal-provincial agreement under which the federal government offers to pay 50 per cent of such bills. Not all provinces have entered into such an agreement.

The benevolent funds represented were charged with negotiating hospital accounts on the same basis as they did with business firms. The latter it was affirmed could afford to cut prices without actual loss, whereas hospitals are strictly non-profit institutions. The policies of these organizations were thoroughly discussed and any misapprehensions were satisfactorily explained by speakers on the panel.

Resolutions

Among the resolutions adopted by the Assembly were those expressing the appreciation and thanks of the Board of Directors to: the Honourable Paul Martin, who was asked to continue in the office of Honorary President; to the officers and directors of the Sun Life Assurance Company for their valued support; to the W. K. Kellogg Foundation; to organizations who sent representatives to the meeting; to the local arrangement committee, the local women's auxil-

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**Deceased, see page 70*

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iaries, and the Sisters of the Order of the Grey Nuns of the Cross—all of whom made the stay in Ottawa more enjoyable; to the management and staff of the Chateau Laurier; to the MacLaren Advertising Company who lent valuable assistance in the matter of publicity and press relations; and to members of the head quarters' staff of the Council.

It was also resolved that a vote of thanks be extended to the outgoing officers and directors, having in mind especially Mr. Fraser Armstrong, who by virtue of the Constitution, ceases to act on the directorate.

An important resolution requested that the Board of Directors appoint a representative committee for the purpose of considering the following recommendations contained in the president's report:

1. That each provincial association become a division of the national association entitled, by constitutional provision, to specified representation on the assembly and on the executive board of the national association.

2. That the annual budget of the national association be distributed equally over all the hospitals of Canada on a bed-basis or other equitable arrangement.

And be it further resolved that the Committee be requested to consider and recommend such other changes to the by-laws as may appear to be desirable as a result of its studies.

And be it further resolved that the Committee be requested to see that all member organizations are consulted and are kept informed of its activities and proposals.

And further that the Committee be requested to submit its recommendations to the Board of Directors in ample time to permit the directors to order notice of motion to be sent to all members so that, if the recommendations involve constitutional changes likely to be acceptable to the members, they may be effectively approved at the next biennial meeting.

It was resolved that the Board of Directors request the Education Committee to study and report upon the recommendations of the Chairman of the Committee on Accounting and Statistics that a course on accounting and statistics be inaugurated.

A resolution was passed recommending to the Board of Directors that they consider holding the next biennial meeting at Banff, Alberta, possibly the week of June 20th.

A resolution was passed thanking Mr. J. Collins of the Canadian Society of Radiological Technicians for his excellent presentation to the meeting and it was recommended that his brief be referred to the incoming Board of Directors for consideration and appropriate disposition.

It was also resolved that the Association express thanks to the Honourable Paul Martin for the continuation and extension of the National Health Grants Program, requesting that the Canadian Hospital Association be consulted when any further changes or additions are being considered.

Fifty Bursaries to Aid Mental Health Program in Ontario

Fifty bursaries from federal health funds have been awarded to residents of Ontario in the current academic year to help them with advanced studies in psychiatry, psychology, psychiatric social work, and psychiatric nursing.

A shortage of adequately-trained men and women to staff new and expanding services is one of the major hurdles in developing an adequate mental health program in Canada, stated the Hon. Paul Martin, minister of National Health and Welfare. The bursary program in Ontario, costing more than $133,000 a year, is an attempt to overcome this situation, to provide more medical and nursing staff for Ontario's mental hospitals, and to obtain adequately-trained men and women for child guidance clinics and other community mental health services. The training program is being carried through with the co-operation of the province's universities and medical schools.

All trainees are enrolled either at the University of Toronto or the University of Western Ontario, London, except two who are studying at the Philadelphia Child Guidance Clinic. Twenty-one doctors are enrolled in psychiatry or child psychiatry; 11 nurses in psychiatric nursing; 11 in psychology; and seven in psychiatric social work. ●

French Translations

The Canadian Hospital Association, and especially its French-speaking delegates, owes a debt of gratitude to those able bi-linguists who quickly and concisely summed up each address and each discussion in the French Janguage. Among these were: Rev. Father Hector Bertrand; Dr. Gerald LaSalle; Roland Levert; Roger Chartrand; and Ray Carriere.

Officers and Directors Elected

Honorary President: Honourable Paul Martin, Minister of National Health and Welfare.

Honorary Vice-President: O. C. Trainor, M.D. Misericordia Hospital, Winnipeg, Man.

President: A. C. McGugan, M.D., University of Alberta Hospital, Edmonton, Alta.

1st Vice-President: Rev. Father Hector L. Bertrand, S.J., 325 St. Catherine Road, Montreal.

2nd Vice-President: W. Douglas Piercy, M.D., Ottawa Civic Hospital, Ottawa.

Treasurer: A Lorne C. Gilday, M.D., C.M., 478 Mountain Ave., Westmount, Montreal.

Directors: Rev. Sister M. Ignatius, Sisters of St. Martha, Antigonish, N.S.,; Percy Ward, 129 Osborne Road East, North Vancouver B.C.; J. Gilbert Turner, M.D., C.M., Royal Victoria Hospital, Montreal; Donald F. W. Porter, M.D., The Moncton Hospital, Moncton, N.B.; John Smith, Yorkton General Hospital, Yorkton, Sask.; A. J. Swanson, Toronto Western Hospital, Toronto, Ont.; Rev. Father John G. Fullerton, 67 Bond St., Toronto.

In his inaugural address to the assembly, Dr. A. C. McGugan, newly elected president, submitted that "the greatest problem before hospital administrators today is that of allocating a judicious share of emphasis on each of the phases of the triad of hospital administration — the spiritual, the mental, and the physical." (His presentation will appear in full in a forthcoming issue of the journal.) In summing up the responsibilities of the national association, he declared: "In all our deliberations and negotiations in the Canadian Hospital Association we will endeavour to preserve that dignity and autonomy befitting the national organization of a great service in a great nation." ●

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Provincial Notes

British Columbia

ESSONDALE. Tenders have been called for the construction of a new 230-bed hospital which will house patients at the Provincial Mental Hospital who are suffering from tuberculosis. It is expected that construction will get under way shortly on the $1,250,000 building. The federal government has allotted $345,000 to help toward the cost of construction.

Alberta

EDMONTON. At an official ceremony on May 1st, the new $2,000,000 wing of the Edmonton General Hospital was opened. The six-storey structure has accommodation for 203 patients.

* * * *

HANNA. Space on the ground floor of the Hanna Municipal Hospital, formerly occupied by nurses, will be renovated and converted into accommodation for eight additional patients, bringing the hospital's total bed capacity to 43.

* * * *

VIKING. The new wing of the Viking Municipal Hospital was officially opened at the beginning of this month.

Saskatchewan

ESTON. Plans are under way for the construction of a new hospital to replace the Union Hospital which was destroyed by fire in December. The new hospital will have 25 beds and a six-bassinet nursery. Medical, obstetrical, x-ray and laboratory facilities will be provided as well as space for a community health centre.

* * * *

MOOSE JAW. The City Council recently received notification that the plans for the proposed new wing to the General Hospital have been approved by the provincial department of public health and that the local government had approved and confirmed expenditures of $1,601,670 for the construction.

Ontario

ATIKOKAN. A campaign was launched at the beginning of last month to raise funds for the Atikokan General Hospital. The funds will be used for the immediate expansion of the present 15-bed hospital to 30 beds. Future plans call for the extension of the hospital to 102 beds.

* * * *

HAMILTON. The city board of control recently gave its approval in principle, subject to the approval of the city solicitor, to plans by the Board of Hospital Governors for the construction of a children's wing at the Mountain Brow Hospital. This matter will most likely be submitted to the ratepayers at the next civic election.

* * * *

LONDON. Plans for the early construction of a 400-bed group of buildings here, to form the nucleus of a large Western Ontario mental hospital, are among construction projects to be undertaken by the provincial department of public works.

* * * *

LONDON. St. Joseph's Hospital has been awarded a $21,000 capital grant by the provincial government to help finance a 21-bed floor for nurses' accommodation. The nurses' rooms will be located on the fifth floor of the new east wing which is presently under construction. This unit will provide accommodation for the supervisory nursing staff, all of whom are members of the Congregation of the Sisters of St. Joseph.

* * * *

LEAMINGTON. The Leamington District Memorial Hospital experienced its most successful year to date in 1952. Reports, given at the annual meeting of the hospital's board, showed that the hospital had ended the year with a surplus of $1,121.58, as compared with a deficit of $14,969.26 in 1951. There was a notable increase in total revenue for the hospital. In 1951, the revenue was $130,292.46, while the 1952 figure reached $149,030.29. Although the revenue was greater there was no appreciable difference in total expenses between the two years.

* * * *

NIAGARA FALLS. The board of governors of the Greater Niagara General Hospital, by a unanimous vote at a recent special meeting, rejected the decision of the municipal councils to build the proposed new hospital on the present site. The board re-affirmed its stand, taken in January, that a new hospital on a new site, which would be the nucleus of a larger hospital in the future, was required to meet the needs of the area.

* * * *

NORTH BAY. George N. Williams, deputy minister of the provincal department of public works, announced recently that construction would begin this summer on a 1,200-bed mental hospital, to be built near North Bay. The site has not yet been chosen but the provincial government has appropriated $9,000,000 for the project during the current fiscal year.

* * * *

OTTAWA. The tender of $669,199, for construction of the nurses' education building at the Ottawa Civic Hospital, has been accepted by the hospitals' trustees. The building will be a two-storey structure, with basement, fronting on Parkdale avenue, between the north end of the nurses' residence and Ruskin avenue. On the main floor of the brick structure will be four nursing arts laboratories and four classrooms, two of which will be large

(Continued on page 98)

With the Auxiliaries

Gift Shop to be Established at St. Mary's Hospital, Montreal

The ladies auxiliary to the St. Mary's Hospital, Montreal, P.Q., will open a gift shop and coffee bar at the hospital this year. The executive has set aside $4,000 for the project. Lack of accommodation has delayed the opening but the required space will be available later in the year. It is hoped that the revenue from the shop and coffee bar will enable the group to render greater financial assistance to the hospital.

The financial report for the past year showed that total receipts were $7,500. After all necessary commitments had been paid, there was a balance of $4,315. The auxiliary's share of the proceeds from the St. Mary's Ball was $1,500 and another $1,500 had been left in the trust by the previous year's executive for the gift shop and coffee bar. The Fireside Bridge Tournament, held in the homes of the various members throughout the year, realized a profit of $927.

Donations during the year included: $100 to the Nurses' Emergency Fund; $130 for nursing service provided for needy patients; $50 for prayer books; a rocking chair; Christmas stockings for the children's ward; Christmas gifts for patients and staff; flowers for the chapel at Christmas; a prize for a student nurse at graduation; masses for deceased members; and the purchase of flannelette for nightgowns. This auxiliary has a total membership of 430,including 27 new members.

* * * *

Auxiliary at Belleville, Ont. Presents Autoclave to Hospital

An autoclave, valued at $950, was presented to the Belleville General Hospital by the ladies auxiliary in April. It will be used in the formulae room. The auxiliary is also building up a reserve fund to help with some worth while project in connection with the hospital's expansion program. To date some $3,000 has been invested in bonds. National Hospital Day was celebrated by members of the auxiliary by conducting visitors through the hospital and holding an exhibit of many donations made to the hospital by the auxiliary. The tour was followed by tea served to the guests in the nurses' residence.

* * * *

Babywear Showcase Sponsored by Auxiliary at Prince Rupert, B.C.

A new babywear showcase at the Prince Rupert General Hospital, Prince Rupert, B.C., is being maintained by the ladies auxiliary. An electric aspirating pump and a thermotic drainage pump were recently purchased for the hospital at a cost of $250. Money is raised by holding progressive bridge parties and three teas during the year, on Hospital Day, Valentine Day, and at Hallowe'en. Magazine subscriptions amounting to $103 were purchased for the hospital library.

* * * *

Auxiliary Helps to Control Sunday Visiting at Hospital

Soon after the new Port Colborne Hospital, Port Colborne, Ont., was opened a problem arose on how to control Sunday visitors. The administration decided on a system of allowing two admission cards for each patient and the hospital's auxiliary was asked to assist with this project. Each Sunday, volunteer workers hand out admission cards at the information desk. The visitors are asked to limit their visits and return the cards promptly so that other people may visit the patient in turn. This system has been in operation at the hospital for over a year and has proved most successful.

* * * *

Active Auxiliary at Abbotsford, B.C.

When the new 52-bed Matsqui-Sumas-Abbotsford General Hospital was opened the ladies auxiliary acted as guides for the 200 guests who were present to inspect the hospital. A rummage sale in February brought in a total of $234 and a very successful flower sale was held in April.

* * * *

New Auxiliary Formed

In April, a new auxiliary was formed at Vermilion Bay, Ont., to serve the hospital at Dryden, Ont. Three auxiliaries now work for the hospital; the other two are at Dryden and Eagle River.

* * * *

Cystoscopic Table Donated to Cornwall General Hospital

The main project, during the past year, of the women's auxiliary to the Cornwall General Hospital, Cornwall, Ont., was the purchase of a cystoscopic table for use in the hospital. Many activities were sponsored by the auxiliary in order to raise the necessary funds. These included: an Easter Bonnet Bridge, featuring a display of hats by a local milliner and a raffle

(Concluded on page 110)

Mrs. J. Cecil McDougall, Montreal, (left), was elected president of the National Council of Women's Hospital Auxiliaries of Canada at their recent annual meeting in Ottawa. Mrs. John Oliver, Edmonton, (right), is vice-president.

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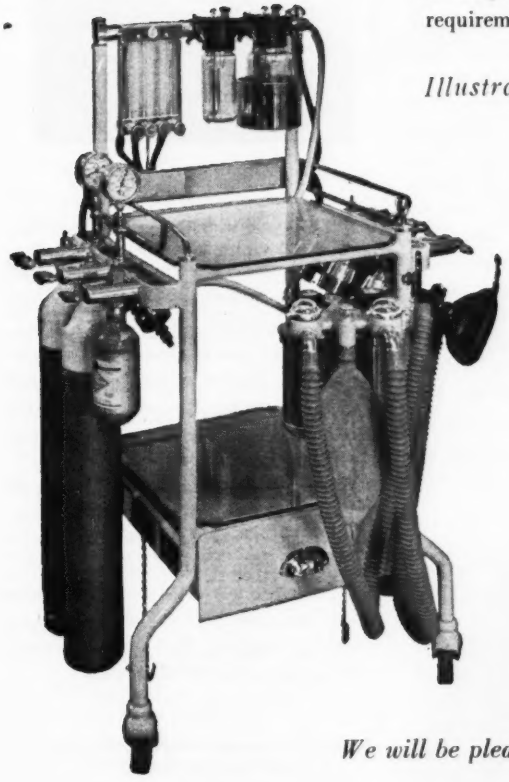

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◄ Notes About People ►

New Medical Assistant at East Windsor Hospital

Dr. C. M. Keillor has been appointed medical assistant at the East Windsor Hospital, Windsor, Ont. He assumed his new duties last month.

A graduate of the University of Western Ontario Medical School, Dr. Keillor served overseas in World War I. After the war, he practised in Kingsville, Ont., for a few years and then served with the Canadian Pension Commission in Ottawa, becoming a commissioner. During World War II, he spent two years with the army medical services and then returned to Kingsville.

* * * *

Sister Beaulieu Appointed Superior at Hotel Dieu Hospital, Windsor

Sister Viola Beaulieu has been appointed superior of the Hotel Dieu Hospital, Windsor, Ont., by the General Council of the Religious Hospitalers of St. Joseph. She succeeds Mother R. Tetrault who is now Assistant General at the Hotel Dieu Hospital in Montreal.

Born in St. Joachim, Ont., Sister Beaulieu graduated from the Hotel Dieu Hospital School for Nursing in 1939. For six years, she was in charge of the surgical ward at Hotel Dieu. She assumed her new duties in April.

* * * *

Margaret Rhynas

Margaret Rhynas, whose name has long been associated with hospital auxiliary work across Canada, died suddenly at her son's home in Toronto, Ont., on May 24th.

A pioneer and enthusiastic leader in the organization of women's hospital auxiliaries, Mrs. Rhynas guided the organization of various women's groups in Ontario into an association in 1929. She prepared its constitution and was its first president, a position which she held for 17 years. After her retirement from the presidency in 1946, she became public relations officer for the association. The dramatic "capping ceremony", so widely used in nursing schools, was originated by Mrs. Rhynas, who also wrote extensive literature on the subject of voluntary aids.

In 1951, the National Council of Hospital Auxiliaries of Canada was formed—another project in which Mrs. Rhynas had played a leading role as organizer and guide. She became its first president—a position she held until last month, when she became past president.

Throughout her years of service to Canadian hospital auxiliaries, Mrs. Rhynas had received many honours, from her own association and from others. In 1948, she was admitted to honorary membership in the American Hospital Association and presented with a citation lauding her many efforts on behalf of auxiliaries in both Canada and the United States. She also received a medal from the late King George VI, in recognition of her work. Upon her recent retirement from the presidency of the National Council of Hospital Auxiliaries of Canada, she was presented with a figurine in Royal Doulton, at the annual meeting held in Ottawa, just prior to her death.

A leader of tremendous energy and enthusiasm, Mrs. Rhynas has contributed much to the hospital auxiliaries of Canada and she will long be remembered not only by the women with whom she worked but by her many friends in the hospital field in this country and the United States.

Margaret Rhynas

* * * *

M. l'Abbé Germain, President, Catholic Hospital Council of Canada

M. l'Abbé Victorin Germain, O.B.E., Montreal, P.Q., was elected president of the Catholic Hospital Council of Canada at the annual meeting held last month in Ottawa.

M. l'Abbé Victorin Germain

Born in St.-Basile, Portneuf, P.Q., in 1890, he obtained his Bachelor of Arts degree from the Seminary of Quebec in 1910 and was graduated from Laval University, Quebec, P.Q., in 1911 with the degree of L.Ph. Continuing his studies at the International Pontifical University of the Angelico in Rome, M. l'Abbé Germain received his D.D. degree in 1919.

Since 1930, he has been director of the Adoptions Bureau, La Crèche, Montreal, P.Q. He is also chaplain of the Association Catholiques des Hôpitaux, Conférence de Québec. Besides being associate editor of a diocesan weekly newspaper, M. l'Abbé Germain is the author of several books.

* * * *

Royal Alexandra Hospital, Edmonton Honours Retiring Staff Members

Two staff members of the Royal Alexandra Hospital, Edmonton, Alta., who retired recently, were honoured by fellow employees at a presentation ceremony. Miss Ann Anderson, assistant superintendent of nurses, received a cheque and a hostess chair and Jack Rennie, superintendent of the laundry, was presented with a wristwatch.

Miss Anderson was born in Manitoba and graduated from the Royal

(Continued on page 74)

1801 ~~1773~~ hospitals have switched to Angelica because of original designs like the

new 'safety-lok' surgeon gown*

*PATENT PENDING

the surgeon gown every hospital is seeking

because...

the (1) "Safety-Lok" tab, which fastens securely and quickly with two indestructible knot buttons, eliminates all ties and provides a comfortable, adjustable fit at the neckline.

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the adjustable "Safety-Lok" neckline feature, the (3) extra four-inch overlap at the back, the (4) absorbent double stockinette cuffs and the (5) 54-inch finished length assure complete safety from contamination.

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the new "Safety-Lok" surgeon gown gives full comfort to the surgeon with (6) roomy raglan sleeves for freedom of movement and (7) tunnel belt for snug fit at the waistline.

Like all Angelica hospital apparel, the "Safety-Lok" surgeon gown is made to last longer. It is available for immediate delivery and priced to your budget. Call your Angelica representative today.

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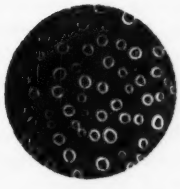
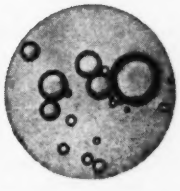


Top — Magnified photo of uniform 8 micron droplets produced by precision-machined suction nozzles of West Atomizing equipment. "Dry mist" remains air-borne for prolonged periods.



Bottom—Magnified photo of droplets produced by ordinary hydraulic compressor sprayers. Vary from 2 to 300 microns. Larger droplets fall, wetting floors and reducing effectiveness.

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Notes About People

(Concluded from page 70)

Alexandra's School of Nursing in 1922. Illness forced her retirement from nursing duties for several years but she returned to the hospital staff in 1937.

Mr. Rennie, a native of Dundee, Scotland, came to Edmonton in 1913. He joined the staff of the Royal Alexandra in 1924.

* * * *

New Officers for Ontario Medical Association

At the annual convention of the Ontario Medical Association held in Toronto last month, Dr. H. T. Ewart, superintendent of the Mountain Sanatorium, Hamilton, was elected president. Dr. R. Morrison Mitchell, Sudbury, became president-elect. Dr. Miln C. Harvey of Kitchener retired as past president of the association to become chairman of the council.

* * * *

Sister Bechand Appointed to Hotel Dieu Hospital, Whitelaw, Alta.

Sister Eugenie Bechand formerly at the Hotel Dieu Hospital in Windsor, Ont., has been appointed Sister Superior of the Hotel Dieu Hospital in Whitelaw, Alta. Born in Windsor, Ont., Sister Bechand received her nurses' training at the Hotel Dieu and took post-graduate work in paediatrics at the Children's Hospital in Montreal, P.Q. She was in charge of the paediatric ward at the Hotel Dieu in Windsor before her new appointment.

* * * *

Honoured by O.M.A.

Three members of the Ontario Medical Association received the association's highest honour at the annual convention held in Toronto last month. Dr. G. E. Eakins, Port Arthur, Dr. Harris McPhedran, Toronto, and Dr. H. W. Kerfoot, Smiths Falls, were all made life members of the association. The T. C. Routley Shield for the best medical society in Ontario was presented to the Thunder Bay Association.

* * * *

H. O. Howitt

Henry Orton Howitt, M.D., died last month at St. Joseph's Hospital, Guelph, Ont., after a lengthy illness.

Dr. Howitt was born in Guelph and received his early education there. Afterwards he attended Upper Canada College and McGill University. After his graduation in 1904, he continued his studies in England. Later he returned to Guelph and established a practice. He was medical officer of health for the city from 1910 to 1920. During World War I, he was chief of surgery at the Speedwell Military Hospital, then in Guelph.

Dr. Howitt had been a director of the Homewood Sanitarium Board and also served on the advisory board of the Guelph General and St. Joseph's hospitals.

* * * *

Arthur Charles Bachmeyer

A well known and respected figure in the hospital field, Dr. Arthur Charles Bachmeyer of Loveland, Ohio, died suddenly last month. He was born in Cincinnati, Ohio, in 1886 and received his medical degree from the University of Cincinnati, in 1911. He served the hospital field for many years as superintendent and medical director of the Christian R. Holmes Hospital, Cincinnati, and the Cincinnati General Hospital. From 1925 until 1934, he was the dean of the College of Medicine at the University of Cincinnati. In 1935 he became associate dean of the Division of Biological Sciences, University of Chicago, and director of University Clinics. In 1934, the University of Chicago offered a post-graduate course in hospital administration and Dr. Bachmeyer became the first director of this course, a position he held until his recent retirement. At the time of his death, he was treasurer of the American Hospital Association. He was also a Charter Fellow of that association and a past president.

A. C. Bachmeyer, M.D.

In Canada, as well as in the United States, Dr. Bachmeyer had become well known, through his connection with the American Hospital Association, his many books on the subject of hospital administration, and through his frequent visits to this country. He has been of great assistance to the Canadian Hospital Association (Council) through his participation in the first summer session of the association's extension course in hospital organization and management. He was on the faculty of the course last summer and had volunteered to take part in this summer's course being held at St. Anne's P.Q. His presence will be greatly missed there this summer and his death will be mourned by his many friends across Canada.

* * * *

Sister Helen Morrissey

The founder and superintendent of the original St. Mary's Hospital on Dorchester St. W., Montreal, Rev. Sister Helen Morrissey of the Religious Hospitalers of St. Joseph of Montreal, died in April, at the age of 92.

Born at Pickering, Ont., she joined the Religious Hospitalers of St. Joseph of Montreal in 1887. In 1923, she founded St. Mary's Hospital, and served as superintendent for many years. The author of two histories of Canadian nursing, Sister Morrissey also started a museum at the Hotel-Dieu Hospital in Montreal. This museum contains equipment used at the hospital more than a century ago, as well as many priceless documents on the early history of Montreal.

- The superintendent of the Grace Hospital, Ottawa, Ont., Major Ida Ellis, has been promoted to the rank of brigadier.

- M. J. Fenwick and John G. Brady were named to the board of directors of the Oshawa General Hospital, Oshawa, Ont., at the annual meeting held in April.

- A. E. Parsons was elected president of the Greater Niagara General Hospital Board, Niagara Falls, Ont., at the annual meeting held in April. Fred M. Cairns was elected vice-president.

(Concluded on page 78)

Here and There

Modern Treatment at an Ancient Spa

Sirmione, the ancient Roman spa, is situated on a small peninsula in the most picturesque part of Lake Garda (Italy), amidst olive and aromatic laurel groves. Sirmione is internationally famed for its natural hyperthermal springs (70°), particularly suitable for the treatment of rheumatism, arthritis, rhinitis, pharynitis, laryngitis, post-infective cardiopathy, metritis, ovariotomy, eczema, and rhinogenous deafness. Courses of treatment last approximately 12 to 14 days, and consist of: baths, mud-baths, inhalations, tubal insufflations, irrigations, as required, all in the modern Hydropathic Establishment or in the "thermal" departments connected with various hotels. The season is from April 1st to November 30th.

The Hydropathic Establishment, which was opened in 1951, is situated near the hotels and is surrounded by a large park overlooking the lake. The rooms for sulphur baths are large, well-aired and lighted. Those for mud-baths are complete with showers, each room being connected with a small air-conditioned cubicle, where patients may rest after treatment. The establishment is also fitted with the most up-to-date equipment for inhalations, nebulizations, nasal douches, and aerotherapy. There are also installations for irrigation and rectal lavages and special cubicles for massage.

The establishment is under the supervision of a physician who is always on duty during the hours of treatment. Treatment is prescribed by the resident doctor. There is a complete and up-to-date research department where all the necessary analyses are carried out.

In June, 1948, the First National Centre for the Cure of Rhinogenous Deafness was opened in Sirmione, after exhaustive research supervised by ear, nose and throat specialists. Experience in this field has confirmed the possibility of curing or at least producing marked improvements in the various forms of rhinogenous deafness. Treatment consists of the insufflation through the nose of certain gases, extracted by a special process from the sulphurated springs of Sirmione. The course of treatment takes from 15 to 20 days, followed up by supplementary inhalations and spraying with the sulphurated water available there. At the commencement of treatment and throughout the course, patients are constantly visited by specialists, who, with the aid of special audiometric instruments, are able to make an accurate diagnosis and assess the degree of improvement.

During 1951, 600 patients were treated at the centre, with a high percentage of complete recoveries and marked improvements. Treatment for deafness is available from May 15th to October 15th. During 1951, a total of 3,584 patients were received at Sirmione.

Reprinted from "Report of a Study Tour of Hospitals in Italy", published by the International Hospital Federation, 1952.

How Old is Medicine?

Antoninus, of senatorial rank, built a maternity hospital at Epidarus in Greece in the year 170 A.D. It was not the first hospital for expectant mothers by many, many centuries. India had them at least 1,000 years before that time. Besides Hindu authorities compelled the physicians and midwives to report every birth. All deaths were recorded also.

An especially large maternity hospital was built in Edessa, Asia Minor, in the fifth century. It developed into a fine medical school. About 200 years later St. John the Almoner became the champion builder of maternity hospitals. He built no less than seven, besides other charitable institutions.

Not long thereafter Siam followed suit. And they had women physicians to treat the expectant mothers.

In the year 1492 physicians tried to save the life of Pope Innocent VIII by giving him blood transfusions. Yes, transfusion is as old as that; in fact centuries older. In very ancient times, Naam, leader of the armies of Ben-Adad, King of Syria, received blood transfusions for leprosy. Blood transfusions also were known to physicians of ancient Greece, Rome, and Egypt.

Along with that, physicians throughout the ages experimented with injecting medicines directly into the blood stream. There was a wave of that right after William Harvey in 1613 announced the discovery of the circulation of the blood. It was so crudely done, however, that the practice was abandoned. Even transfusion was not safe until some 35 years ago. Then it was learned that there are four distinct types of blood and that one will not mix with another.

The medical specialist is not new; he is as old as history. Iry is the most ancient eye doctor known to medicine. He was born in 2270 B.C. in Egypt. But even he wasn't the first because we know that in his day most of the Egyptian physicians specialized in treating different parts of the body. Iry rose high. He became personal physician to the King of Egypt. His title reads: "Director and Dean of the Royal Physicians, Royal Ophthalmologist, Director of Intestinal Diseases, Magician and Scholar".

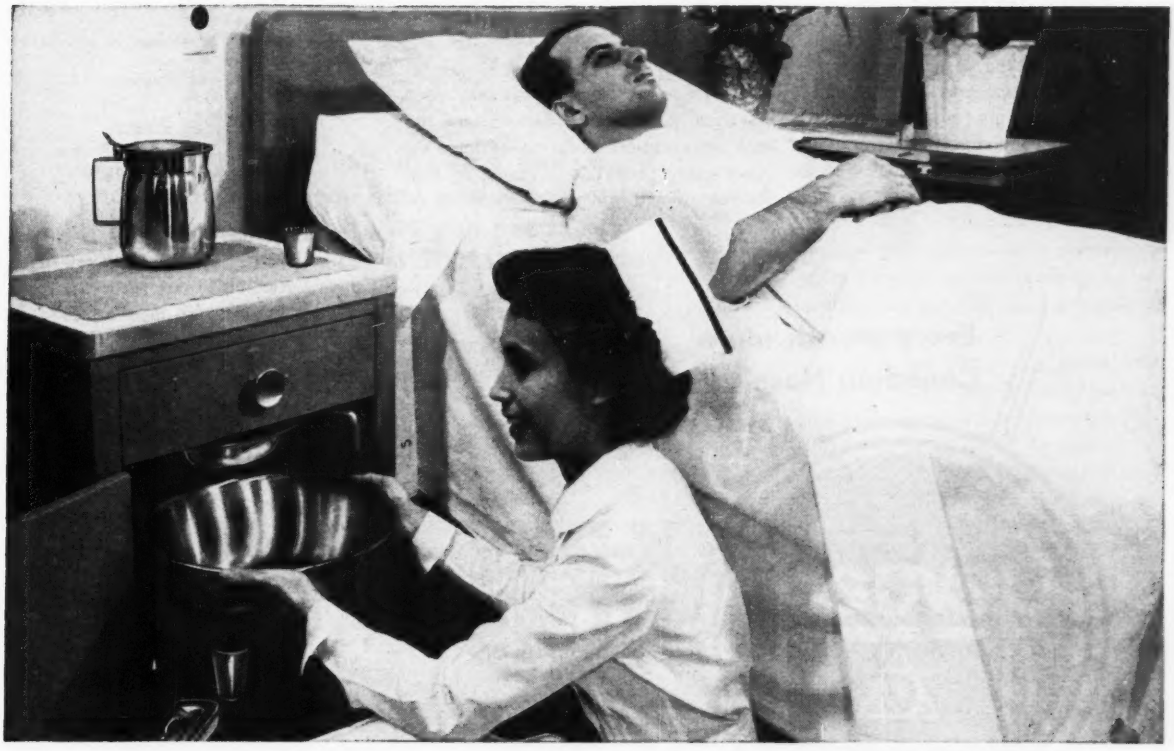
Egyptian physicians were renowned the world over. For hundreds of years kings of many nations sent to Egypt for their doctors. Records show that Cyrus and Darius, the Persians, appealed to Pharaoh to send physicians when they fell ill.

World Health

If sickness and poverty go hand in hand, so also do health and prosperity. The way to world health and prosperity is through international action, for the evil we fight is the enemy of us all—and in this battle there can be no neutrals.—*Brock Chisholm.*

Every generation enjoys the use of a vast hoard bequeathed to it by antiquity and transmits that hoard, augmented by fresh acquisitions, to future ages.—*Thomas Macaulay*

Rx for modern hospital standards



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Correspondence

Early Prepayment Plans

To the Editor:

I am preparing a study on the devolpment of pre-paid hospital care in Canada and am most anxious to obtain material on the earliest prepayment plans in the various provinces. There are a number of interesting early examples, including those of Glace Bay, N.S., Nanaimo, B.C., Chatham, N.B., and the Medicine Hat plan in Alberta. On a scale more typical of the present day Blue Cross Plans were the Edmonton, Alta., Moncton, N.B., and Kingston, Ont., hospital care plans of the early thirties.

I wonder if, through the pages of your journal, I might invite your historically-minded readers to send me such information as they may have on other early prepayment plans, so that the record of these important developments may be complete?

All material which anyone wishes to retain would be returned, of course.

Thank you very much.

Yours sincerely,

"Malcolm G. Taylor", Ph.D.,

Assistant Professor,
Politlical Economy,
University of Toronto,
Toronto, Ont.

Notes About People

(Concluded from page 74)

- S. R. Noble, OBE, was re-elected president of the Julius Richardson Convalescent Hospital, Inc., Montreal, P.Q., at the annual meeting held in April.

- William J. White was re-elected chairman of the Crow's Nest Pass Municipal Hospital Board, Blairmore, Alta. Joseph Zemek was appointed vice-chairman.

- V. B. King was elected president of the Woodstock General Hospital Board of Trustees, Woodstock, Ont. J. A. Vance is the new vice-president.

- R. W. Robson is the new chairman of the Winnipeg and District Joint Hospital Committee, Winnipeg, Man. Mrs. W. Bryans is the first vice-president.

- Mrs. George C. Chandler has been elected president of the Children's Hospital, Vancouver, B.C., for 1953. She succeeds E. S. H. Winn, QC, who resigned, for reasons of health, after 13 years of service. He was presented with an honorary life membership in the form of an illuminated scroll.

- Malcolm Cochran was elected president of the Board of Governors of the Port Arthur General Hospital, Port Arthur, Ont. Gordon McDougall is vice-president.

Deception

In the long run it makes little difference how cleverly others are deceived; if we are not doing what we are best equipped to do or doing well what we have undertaken as our personal contribution to the world's work, at least by way of an earnestly followed avocation, there will be a core of unhappiness in our lives which will be more and more difficult to ignore as the years pass.—*Dorothea Brande*

With clean, convenient ice cubes or "cubelets"

Frigidaire Now Solves All Your Ice Supply Problems!

All you ever do is open the door and scoop out the ice you need . . . up to 200 pounds a day for as little as 26¢ a day!

Put an end to uncertain ice deliveries, impurities, costly, messy melting. With a Frigidaire Automatic Ice Cube Maker you always have plenty of sparkling clear solid ice cubes for cold drinks, chilling food and a hundred and one other uses.

Convenient bin stores about 100 lbs. of cubes or cubelets ready for use, and the supply is constantly replenished. No trays to fill or empty, no water to turn on or off, no extra handling. Attractive, flat-top cabinet. Uses little floor space. Fits under counters. Powered by famous Meter-Miser Compressor warranted for five years. Look for your Frigidaire Dealer in the Yellow Pages of phone book. Or write Frigidaire Products of Canada Limited, Scarborough (Toronto 13), Ontario.

Two models make pure ice in two convenient forms:

New Ice "Cubelets" obsolete crushed, cracked, flaked ice

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Regular size Solid Ice Cubes— no holes, no odd shapes

Crystal-clear, mineral-free, solid ice all the way through—1¼" x 1⅛" x desired thickness, just right for cooling water, mixed drinks and every ice cube need.

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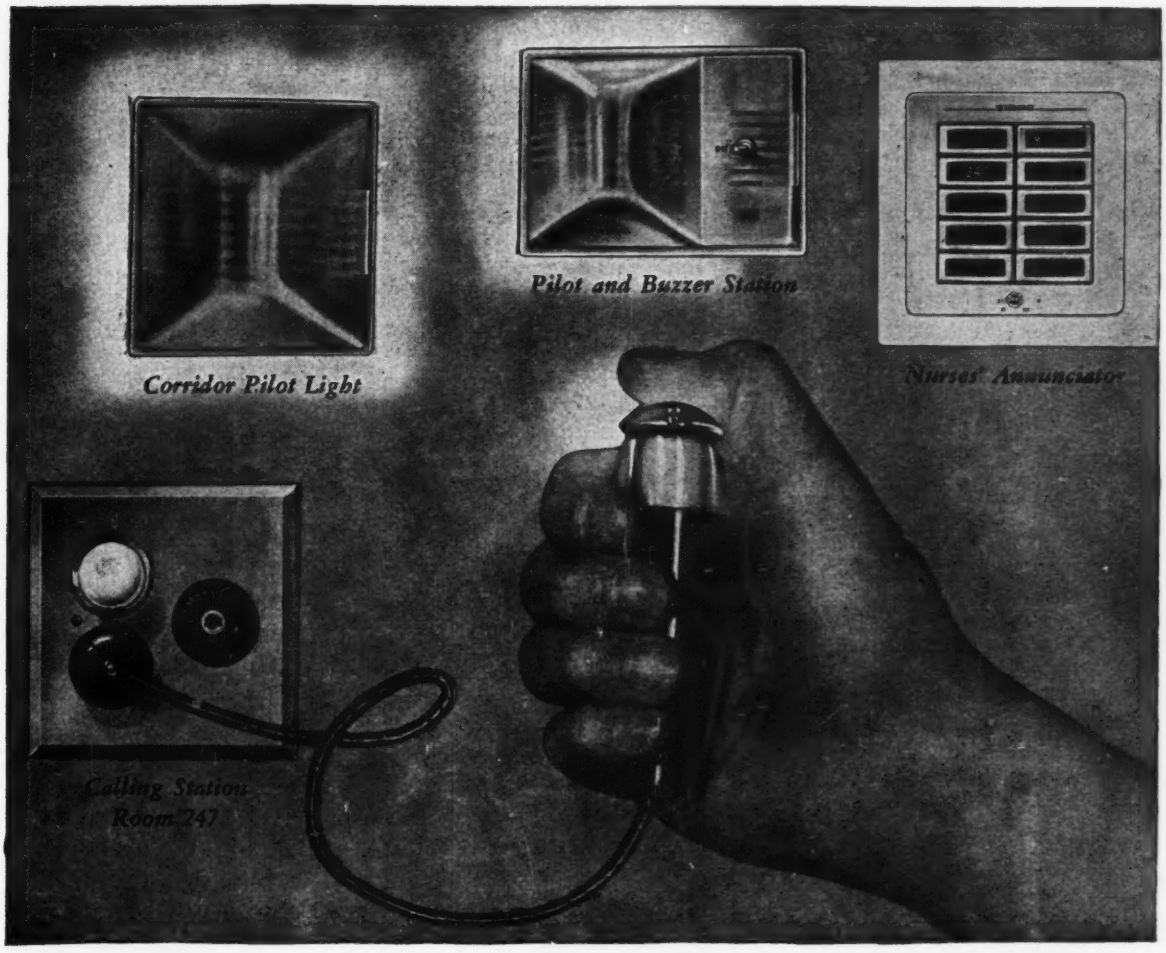

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When a patient signals by pressing the Nurses' Call Button, the IBM System goes into operation quickly and efficiently.

A Signal lights on the patient's own calling station, assuring him that the system is functioning. Simultaneously the corridor pilot light over the room door is illuminated, as well as the pilot and buzzer stations located in diet kitchens and utility rooms. The number of the patient's room is lighted on the Annunciator at the Nurses' Duty Station, indicating to the nurses which room has registered a call.

The new IBM Locking Button has a luminous glow which enables the patient to find it easily at night. It is light, attractively designed, and is protected against accidental resetting.

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1953-54 Outline of Federal Health Grants

A grand total of $48,503,826 will be available as grants-in-aid from the federal government to the provinces for the development of health services and hospital construction in the current fiscal year according to orders-in-council tabled recently in the House of Commons by the minister of National Health and Welfare, the Hon. Paul Martin.

Largest single grant is for hospital construction — $19,850,651. This includes a carry-over of $12,993,767 to complete building projects for hospitals, nurses' residences, community health centres, and combined laboratories which were approved prior to April 1st, 1953, and whose construction is commenced before October 1st, 1953. The remainder of the amount—$6,856,884—is available for new projects. Total amounts available by provinces are: Newfoundland, $403,706; Prince Edward Island, $141,623; Nova Scotia, $864,590; New Brunswick, $918,453; Quebec, $4,388,707; Ontario, $7,808,956; Manitoba, $971,160; Saskatchewan, $2,066,522; Alberta, $766,575; British Columbia, $1,497,340; Northwest Territories, $14,473; and the Yukon, $8,582.

Total amount allotted for other health work, including the three new grants for medical rehabilitation, child and maternal health, and diagnostic services, is $28,140,275. Allottments by provinces are: Newfoundland, $883,254; Prince Edward Island, $277,753; Nova Scotia, $1,321,340; New Brunswick, $1,099,000; Quebec, $8,289,484; Ontario, $8,745,168; Manitoba, $1,583,294; Saskatchewan, $1,645,289; Alberta, $1,874,272; British Columbia, $2,352,107; Northwest Territories, $43,262; and the Yukon, $26,052.

A grant of $512,900 has been set aside for public health research. This is *not* divided on a provincial basis but is allocated to promising research projects on the recommendation of a special advisory committee of the Dominion Council of Health.

The grants for crippled children ($519,898), professional training ($516,300), mental health ($6,203,652), tuberculosis control ($4,239,551), general public health ($7,215,000), and child and maternal health ($500,000) are grants-in-aid to the provinces to develop new and expanded services. The grants for hospital construction ($19,850,651); venereal disease control ($518,099); cancer control ($3,598,795); medical rehabilitation ($500,000), and diagnostic services ($4,329,000), require provincial contributions.

Service to Others

Man cannot live by bread alone. The making of money, the accumulation of material power, is not all there is to living. Life is something more than these and the man who misses this truth misses the greatest joy and satisfaction that can come into his life —service to others.—*Edward Bok*

Every successful man I have heard of has done the best he could with conditions as he found them and not waited until next year for better.— *E. W. Howe*

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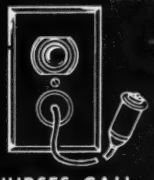

NURSES CALL SYSTEM

FIRE ALARM SYSTEM

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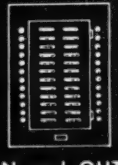

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Nursing Education

In response to requests formulated by the WHO Expert Committee on Nursing, a working conference on nursing education was convened by the organization . . . This report shows how, in every country, nursing services follow a pattern of development parallel to that of the health services. Once they reach a certain stage, there begins to be felt a need not only for more nursing personnel but also for personnel who are better qualified. This constant evolution, which results from general economic and social improvement, makes the organization of nursing services anything but static and abolishes all rigidity in training of nurses.

Progress in medicine and social, economic, and technical development, bring increasing responsibility to nurses and add to the importance of their functions. In fact, the physician, who becomes more and more involved in specialized work, delegates to the nurse certain tasks which were formerly his; this is true also of the public health officer. The nurse assumes a co-ordinating role: through her direct contact with the patient she helps him to benefit from all the resources available to him in the public health team. In addition, she must supervise the work of auxiliary personnel and train student nurses. She must therefore possess, besides her professional training, a maturity of mind which will enable her to analyse the type of care which a patient requires, to seek continued growth and educational development, and to instruct others—the patient and his family as well as auxiliary personnel.

Teaching by a method known as the "situation approach" is the best means of preparing the nurse for her work. This method offers her opportunities to acquire direct experience of a great variety of situations, through which she may develop her understanding and skills. Faced with a particular case, the student nurse will first draw upon her knowledge of nursing theory and then upon the previous nursing experience which she has had. She must be familiar with a number of different subjects — anatomy, physiology, and chemistry, for example. Application of principles of psychology and mental hygiene will aid her in adopting the proper attitude towards the patient; knowledge of sociology will be useful to her in understanding the milieu from which the patient comes.

However, the "situation approach" can be introduced into nursing schools only gradually. The report contains a study of the conditions under which such teaching may be developed and suggestions as to how it may be integrated into the general program of nursing care. A table, given in an annex, shows how formal instructions may be combined with actual "experience" to give the desired result—training of a type which will produce a nurse qualified in every way for her work.

The nurse described in the report represents an ideal; nevertheless, it is important that local, national, and international groups concerned with the training of nurses should not lose sight of this goal. — *From "Chronicle of the World Health Organization", March, 1953.*

Doctors don't expect them

Nobody seems to know for sure, but it may have been a newspaper writer who first started talking of awarding an orchid to men or women he admired. Probably no one has ever heard of a doctor getting an orchid, but Canadian doctors have earned more world-wide praise than the distinguished men of most professions.

In the matter of child-rearing and child nutrition Canada holds a particularly outstanding place, because of the many unusual cases that have been treated so successfully.

We, at Heinz, where Infant feeding has been a specialized study for years, join in wishing the Canadian medical profession further success, and a continuance of the good relations which have enabled us to produce new baby food varieties that meet with their acceptance

Heinz

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Modernizing Dietitic Facilities

(Concluded from page 36)

be loaded. We expect that elimination of this step will save us labour, time, and inconvenience.

New Snack Bar

The area across from the lift room was previously used as a lunch rom for employees who carried their lunches. It was drab and airless. Free tea and milk were provided if the employees brought drinking utensils. Today this room has become a small, modern, self-contained snack bar. It has a seating capacity of 135 and has a daily patronage of over 1,600. In this cafeteria, we sell tea, coffee, milk, hot soup, sandwiches, assorted pies, and baked goods, at a figure to cover costs plus labour. Since the main kitchen was already strained beyond capacity when the cafeteria was opened, it was decided that all food must be brought in from outside ready to serve. Therefore, we use 48-oz tins of canned soup, heated in electrically operated soup tureens, and cooked block ham, sliced cheese, tuna, salmon, tomatoes, et cetera, for sandwiches. Mayonnaise is purchased daily in gallon jars as well as doughnuts, muffins, sheet cakes, cupcakes, and pies. An ice cream freezer houses ready-made sundaes, bars, and dixies of ice cream. We do not serve soft drinks but sell ice cold fruit juice all year round. Everything is served on paper with the exception of soup and coffee. Sandwiches are served in glassine bags with pickle slices; and milk comes in half-pint cartons. This cafeteria fills a long-felt need and its operation is exceedingly simple. Sometime this year a commercial-type cafeteria will be opened on the second floor where a variety of foods, including hot meals and salads, will be available.

Across from the lift room is a second delivery entrance. All milk is received here and housed in our now spacious dairy refrigerator until delivery to the various buildings. Shortening, margarine, and butter are stored in boxes on platform racks in this refrigerator. All platform racks are built the same height as the truck platforms. Outside the refrigerator there is ample space for empty cans and racks of bottles awaiting return to the dairy. All vegetables are also received at this delivery entrance. The vegetable room is opposite the milk room, to the left of the delivery entrance. Root vegetables are stacked on tricky little mobile trucks as they come down the delivery chute. They are stored on these trucks until they go through the peeler, thus eliminating additional handling. The vegetable peeler ejects the peeled vegetables into a deep stationary sink. After "eyeing", potatoes are dropped into a second container, similar in size to the sink. This potato tub is mobile and fitted with a drain. It may be filled from one of two sets of wall taps. It is drained over a wide floor sump fitted with a smooth mesh grating which runs the full length of the peeling area. We find that the sump keeps this operation clean and dry for the workers. The mesh grating is in easily removable sections and the sump has a large drain which is easy to hose down. Hose bibs are conveniently located.

Along one side of the vegetable room is a large refrigerator. It is used for storage of all perishables and contains a storage cabinet for frosted foods. Back to back with this refrigerator is the fish refrigerator. Across from the latter are large deep sinks and cutting boards used in the preparation and cutting of fish.

The vegetable preparation area is fitted with sinks, scales, cutting boards and stools of various heights. We hope to add a vegetable dicer this year.

The total basement area is well-tiled throughout. There are numerous floor drains strategically placed to facilitate frequent hosing. All sinks are free standing, away from the walls by about 6½", thus sink areas are easily cleaned and seepage and filth are eliminated behind splashboards. This spacing also will facilitate plumbing repairs when they become necessary and is an important factor in pest control. Taps on all sinks are manually-operated mixer valves and drains are lever-operated. All racks and tables are on castors and are designed to be efficient in use, and easily cleaned, as well as to reduce the handling of produce.

All of this equipment is neither spectacular nor original in design but is simple, sturdily constructed, and functional—and we enjoy using it.

An Island Universe

Each man is an island universe in the cosmos, with the stars forming above him and the tides of joy and sorrow in ebb and flow about him.—*E. P. Scarlett, M.D.*

Cues for Building Up a Stable Staff

High ideals, straight thinking and a skillful performance are three fundamentals to success in any honourable field of work. It takes a combination of all three to bring success no matter what the undertaking. The successful nurse administrator is one who can draw from people the muscle power, brain power, and feeling power to fulfil the purposes of the agency. Skill in handling human relations is essential wherever one person becomes responsible for another's work. Such skill is the art in administrative science.

All human beings are motivated by similar factors pertaining to their work, such as: (1) financial incentives including cash wages, benefit programs, security; and (2) job satisfaction through opportunity to use one's abilities, opportunity to grow on the job, take on more responsibility, to show capacity to advance on the job, and desirable work situation.

Financial incentive is never enough. The other factors loom as important, if not more so, in job satisfaction. With these motivations in mind, cues for maintaining relationships which will build a stable staff are logical. They may well form a pattern of behaviour for nursing administrative and supervisory personnel:

1. Treat people as individuals. If no more, a cheerful good morning, a smile or nod of recognition of the person means a lot.
2. Establish common understanding. It is the other person who must understand you, if you wish a starting point for pulling all hands together to work for good service.
3. Let co-workers know what management is trying to do.
4. Let co-workers know how they measure up.
5. Respect the feelings of other people. Feelings are facts to people. If need be, feelings must be changed to secure whole-hearted response.
6. Remember the method and the manner are often more important than the words you say. — *Hospital Nursing "Newsletter", National League for Nursing, February, 1953.*

Bleaching

The correct use of bleach is an important part of the washing process. Its value lies in the fact that it sterilizes, aids stain removal, and helps whiten the fabric. If your water is high in alkali content it is impossible to wash clothes white. You must bleach them white. Bleach should be used in the last suds after the loose dirt has been washed out. Remember — you can not wash clothes white, you can not bleach clothes clean.

The accepted standard for bleaching is to use two quarts of a bleach solution with a strength of 1 per cent available chlorine to every 100 pounds (dry weight) of white work. This proportion is found to give the maximum bleaching qualities with the minimum loss of tensile strength. Bleach may be purchased in two forms: as a high-test bleaching powder, or in liquid form.—*The Canadian Laundry Machinery Co. Ltd.*

Live and . . . Earn

Education is not given for the purpose of earning a living; it's learning what to do with a living after you've earned it.—*Abraham Lincoln.*

Coming Conventions

June 14—Annual Convention of the Catholic Hospital Conference of Saskatchewan, St. Paul's Cathedral Hall, Saskatoon.

June 15-17—Annual Convention of the Canadian Dietetic Association, Chateau Laurier, Ottawa.

June 15-19—Annual Convention of the Canadian Medical Association, Royal Alexandra Hotel, Winnipeg, Man.

June 15-19—Western Canada Institute for Hospital Administrators and Trustees, University of Saskatchewan, Saskatoon.

June 20—Annual Meeting of the Saskatchewan Hospital Association, Saskatoon, Sask.

June 22-24—Convention of the Comité des Hôpitaux du Québec, le Collège St. Laurent, St. Laurent, P.Q.

June 22-26—Annual Convention of the National League for Nursing, Cleveland, Ohio.

June 28-July 2—First Joint Convention of the Canadian Society of Radiological Technicians and the American Society of X-Ray Technicians, Royal York Hotel, Toronto.

Aug. 31-Sept. 3—Annual Convention of the American Hospital Association, San Francisco, Cal.

Sept. 7-12—International Congress of the World Confederation for Physical Therapy, Central Hall, Westminster, London, Eng.

Oct. 1-3—Annual Meeting of the Canadian Public Health Association, in conjunction with the annual meeting of the Ontario Public Health Association, Royal York Hotel, Toronto.

Oct. 13-15—Annual Convention of the Associated Hospitals of Manitoba, Royal Alexandra Hotel, Winnipeg, Man.

Oct. 19-21—Annual Convention of the Associated Hospitals of Alberta, Macdonald Hotel, Edmonton.

Oct. 26-28—Ontario Hospital Association Convention, Royal York Hotel, Toronto.

Oct. 27-30—Annual Convention of the British Columbia Hospitals' Association, Hotel Vancouver, Vancouver, B.C.

Oct. 29-30—Annual Convention of the Ontario Conference of the Catholic Hospital Association, St. Michael's Hospital, Toronto.

Tuberculosis Survey Planned for Western Arctic

A flying public health party will carry out an extensive x-ray survey for tuberculosis among the Eskimos along the shores of the western Arctic. The group, headed by Dr. L. Christensen, Indian Health Services doctor at Aklavik, N.W.T., plans to visit settlements along the coast and on the Arctic islands, including, Coppermine, Cambridge Bay, and Pelly Bay. The exact number of persons who will be x-rayed will depend on whether flying conditions permit the x-ray party to reach all their scheduled stops and whether the Eskimos can get to the settlements. However, it is hoped that about a thousand will be x-rayed. Duration of the survey will depend on flying conditions. In addition to the medical officer, the group includes three technicians to handle the portable x-ray equipment.

This expedition is one of a series organized by the Indian Health Services of the federal health department. Mass x-ray surveys of Indians have proved an effective method of detecting tuberculosis and, along with good hospital care, have brought a substantial reduction in the tuberculosis death rate among Indians. It is hoped that this program can be extended to the Eskimos in the most remote areas.

Medical work among the Indians and Eskimos of the Mackenzie district is organized from the Charles Camsell Indian Hospital, Edmonton, Alta.

Ont. Blue Cross Spent $18 Million in 1952

Approximately $18,800,000, representing 85.1 per cent of the year's total subscription income, was used to provide hospitalization for subscribers to the Ontario Blue Cross Plan. This figure surpasses the 1951 total by well over $3,000,000. There was also a net increase in enrolment of nearly 100,000 participants in 1952, bringing the total enrolment to approximately 1,675,000.

Provincial Notes

(Continued from page 66)

enough to hold nurses' meetings. The second floor will contain three laboratories, a large library, and offices. Provision will be made in the basement for lockers for graduate, private duty, and student nurses, also for wash rooms, and a main linen distribution room. The building will be connected with the main hospital buildings by a tunnel.

* * * *

PORT CREDIT. Proposed plans are being drawn up by the South Peel Hospital Board for the construction of a 50-bed hospital to serve the southern portion of Peel County. Building costs are estimated at $600,000 and it is expected that a drive for funds will be launched this fall. It is hoped that the hospital will be in operation by 1954.

* * * *

SCARBOROUGH. A campaign to raise $750,000 toward the construction costs of the new $2,200,000 Scarborough General Hospital was launched recently. The hospital, to be located on 30 acres of land at Lawrence ave. and McCowan rd., will have 125 beds. A school of nursing is expected to be established within a few years.

* * * *

STRATFORD. The Stratford General Hospital Trust has approved wage increases for hospital employees of $7.50 a month, totalling $35,000 a year. The board was advised that a bargaining committee had agreed on the pay increase, retroactive to February 1st. Also included in the agreement was a 44-hour work week, which will necessitate increasing the staff by nine employees. Under the new agreement, 160 permanent employees will receive an additional $13,200; nine new staff members will add $16,710 to the payroll; and regular annual increments for union employees will amount to $3,200 and non-union $1,950.

* * * *

SUDBURY. A three-storey, 30-bed psychiatric rehabilitation centre is scheduled for construction this year as an addition to the Sudbury General Hospital. To cost approximately $255,000, the new building will extend from the west wing of the present hospital. It will contain, in addition to beds and offices, facilities for physiotherapy and special training.

* * * *

WINDSOR. The new 176-bed addition to the Metropolitan General Hospital was officially opened in May. In addition to increased patient accommodation, the wing provides additional space for the laboratory, pharmacy, blood bank, and operating rooms.

* * * *

WINDSOR. The board of directors of the East Windsor Hospital announced recently that occupational and physiotherapy departments as well as a geriatric treatment unit will be established at the hospital shortly. It was also announced that a new eight-hour shift for employees has now replaced the split shift, which had required that many employees work eight hours over a 12-hour period.

Quebec

MONTREAL. Adoption of a plan to add a new wing to St. Luke Hospital was announced at a recent annual meeting. The financial report showed that the 1952 deficit was $83,213.40, a drop of $50,699.02 from the 1951 deficit of $133,912.60. The improvement in finances was due to higher room rates and increased provincial grants for the treatment of public ward patients. Total revenue for the past year was $1,854,243.61 and expenditures were $1,937,452.01. The main reason for the higher disbursement was the increased wages paid to the hospital personnel.

* * * *

MONTREAL. At the 59th annual meeting of the Royal Victoria Hospital board of governors, it was reported that the hospital had its lowest net deficit since 1946 during the past year, although the number of patients admitted was at an all-time high. The net deficit of $187,306 was only 55 per cent of the 1951 deficit of $336,546. The 1952 deficit would have been $551,779 had it not been for income and donations from endowments, the board of governors, and the federal and provincial grants. Total expenditure for the year was $4,002,744 against a total income of $3,815,438.

Construction began on the new seven-storey wing this spring and is expected to be completed in 1955. Four floors will provide accommodation for patients, one floor for operating rooms, a floor for x-ray, diagnosis, and treatment, and a floor for dining rooms. There will be a central supply department in the basement. The main building will be renovated when the new wing is completed.

* * * *

MONTREAL. An appeal to raise funds for a $5,500,000 expansion program for the Jewish General Hospital was launched in May. Included in the proposed expansion plans is a 173-bed addition, a new out-patient department, scientific laboratories, a new x-ray department, additional operating rooms, and a new physical and occupational therapy department, as

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Provincial Notes

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well as modernization of existing facilities.

* * * *

VERDUN. Plans are under way for a new 325-bed admission and treatment building for the Verdun Protestant Hospital. In spite of increased expenditures the hospital ended 1952 with only a nominal deficit of $1,002, compared with a deficit of $86,222 in 1951.

New Brunswick

FREDERICTON. Extension of the north and east wings of the Victoria Public Hospital will increase the patient accommodation by 37 beds and provide increased space for the x-ray and operating room facilities and other ancillary services. Construction is scheduled for completion in about a year.

* * * *

MONCTON. Construction is expected to begin on a $1,000,000 wing for the Hotel Dieu Hospital this summer. The wing, scheduled for completion next year, will have space for 88 additional beds, a 29-bassinet nursery, an outpatient department, and accommodation for 13 nurses. Also included in the building program will be extension of x-ray facilities, a laboratory, and a pharmacy.

* * * *

WOODSTOCK. Construction is expected to begin shortly on a new hospital to replace the present 50-bed Carleton Memorial Hospital. It is hoped that it will be completed next year. The building will have space for 75 patients, a 21-bassinet nursery, and medical, surgical, and obstetrical facilities.

Nova Scotia

SYDNEY. The new St. Rita's Hospital was officially opened at the end of April. Erected and equipped at a cost of $1,800,000, the 163-bed hospital has five floors.

Tips on Laundering Chenille Spreads

The secret of reviving a chenille bedspread is in the drying process, says the American Institute of Laundering, research and education centre for the commercial laundry industry. Commercial launderers, says the institute, use mild detergent for washing chenille spreads. These plants make a standard practice of tumble drying the bed coverings.

Tests conducted by the institute's laboratory reveal that tumble or fluff drying chenille bedspreads gives them a soft, fluffy appearance. The textile experts offer three points to remember when buying chenille spreads. To check the bedspread for quality and launderability:

1. Examine the spread and be sure the muslin backing has at least 60 threads to the inch.

2. Check the colour fastness. Cloth can be either dip dyed or vat dyed. Vat dyeing gives better colour fastness.

3. Examine the embroidery stitches. If they are close together and neat this indicates that the spread is well made. —"*Institutions Magazine*"

RADIOGRAPHIC TECHNIQUE

3

Gradation

Once a film of the right characteristic has been chosen, gradation is governed by a proper combination of exposure time and kilovoltage. Of these, the most important factor is kilovoltage; if this is incorrectly chosen for the particular subject and film in use, no amount of adjustment of exposure will give satisfactory compensation, although small errors will be looked after by the latitude of the film.

A radiograph of good gradation contains a full range of tones from minimum to maximum black, which requires the elimination of all causes of fogging. ILFORD X-ray Films cover the whole field of medical requirements and enjoy a well established reputation for consistency, reliability and freedom from basic fog.

Enrichment

(Continued from page 40)

was more rapid. In 1943, two years after niacin-enriched foods appeared on the market, the rate was 1; and by 1950 it had dropped to .2, representing an unprecedented low of 260 reported deaths in the entire country.

In North America, mortality data do not reflect the true health importance of the deficiency diseases, since very few affected persons die. It is the number of cases—the people limited in their capacity to work and enjoy life—with whom we are especially concerned. I have stated that pellagra cases in the United States about 20 years ago were estimated to number about 200,000, nearly all of which were in the South. Now I will mention a figure indicating a dramatic change. Among 10,000 recent admissions to the Hillman General Hospital in Birmingham, Alabama, not a single pellagrin was found — and this occurred at one of our permanent pellagra research centres in an area where the disease was once rampant.

At the Cincinnati General Hospital, where 34 cases were diagnosed in 1939, only one case was seen from 1946 to 1948. If enrichment had done nothing more than help control this one disease, it would have paid for itself many times over in lives saved and people rehabilitated.

Even among chronic alcoholics, once commonly afflicted, pellagra has become rare. In 1948 and 1949, the Army Medical Nutrition Laboratory examined approximately 16,000 alcoholic inmates of the Chicago House of Correction and found only two with pellagra, three with ariboflavinosis, and one with possible beriberi. The decline of those diseases among alcoholics clearly dates from the introduction of enrichment.

Beriberi is a disease resulting from lack of thiamine, another vitamin of the B group. Like other deficiency diseases, beriberi has no geographical limitations, although more than 90 per cent of the cases are reported among rice-eating peoples. How serious it can be as a public health problem is shown by the fact that, in the Philippines in 1948, beriberi was second only to tuberculosis as a cause of death. Small outbreaks have occurred in such places as Australia, Iceland, and Labrador. In the United States, Great Britain, and other western countries, beriberi has been frequently reported among chronic alcoholics and the inmates of institutions; but it is not an important cause of death among peoples consuming a variety of foods. In its less severe forms, however, there was evidence that thiamine deficiency was sufficiently prevalent in the United States to warrant addition of the vitamin to flour and bread.

Ariboflavinosis — riboflavin deficiency disease — is reported frequently in various parts of the world. It often occurs in conjunction with other B-vitamin deficiencies, especially pellagra. Ariboflavinosis was not recognized as affecting humans until 1939. As a result, the incidence in the United States was not accurately estimated, but there is no doubt of its former prevalence.

Like pellagra, these B-vitamin deficiency diseases — beriberi and ariboflavinosis—have declined in the United States as a result of improved nutrition to which enrichment has demonstrably contributed.

While the demonstrated prevention of specific deficiency diseases is the real test of enrichment, other evidence

(Continued on page 104)

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Enrichment

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of its effect on the nutrition status of the population should not be ignored. Over the past ten or fifteen years, there has been a general elevation in the nutritive value of our national diet. This means primarily a higher vitamin, mineral, and protein intake. As shown in studies by the Department of Agriculture, the most striking increases have been in thiamine, niacin, riboflavin, and iron, with a sharp rise beginning about 1941, when enriched bread and flour were introduced. In 1945 and 1946, the peak years of per capita consumption, these four nutrients exceeded pre-war levels by a third to a half. The average American in 1945, as compared with what he would have received without enrichment, obtained in his food 27 per cent more thiamine, 19 per cent more niacin, 12 per cent more riboflavin, and 17 per cent more iron. It is important to note that the benefits were greatest among the lower income group, whose diet is poorest and incidence of deficiency diseases highest.

Thus, we are able to trace various specific gains due to better nutrition, and even to assign a considerable measure of that progress to the enrichment program. Other advances in health are undoubtedly associated with the nutrition movement, but its contribution is harder to prove. Maternal and infant deaths, for example, have declined to unprecedented levels, a fact for which nutrition can take much credit. Similarly, there have been appreciable increases in growth rate and stature; and we note with interest the downward trends in mortality from infections, particularly tuberculosis, that have paralleled the elevation of nutritional status. The benefits of improved nutrition have exceeded our most optimistic expectations.

By no means, however, does all this imply that our national diet is now perfect, nor that malnutrition in the United States is a thing of the past. I have discussed only the advances, the favourable trends. Many problems still confront us, some of which mount in significances as various factors lengthen the life span and increase the number of older people in the population. One such problem is our high mortality from chronic

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Enrichment

(Continued from page 104)

diseases frequent among the aged, such as cardio-vascular diseases, cancer, diabetes, and cirrhosis of the liver. Another problem, the extent of which is uncertain, is that of borderline dietary deficiencies—conditions presenting an indefinite clinical picture but, nevertheless, one of sub-optimal health.

Further Research Needed

With regard to the problems attacked through enrichment, we know that anaemia, by generally accepted standards, is still widespread in the United States, especially among women. This is thought to be largely nutritional in origin. The commonest form of anaemia — secondary, or hypochronic— is attributed to iron deficiency; but the incidence has shown little change, despite the increase in the average consumption of iron. Does this mean that the problem is overestimated because of an unrealistic health standard, that iron is poorly utilized, or that iron deficiency is not responsible for the condition? Only further research can provide an answer.

There are many other important research problems in nutrition. Our approach to these problems must remain broad. The history of science shows conclusively that the long-range point of view—with the emphasis upon fundamental investigation, often with little promise of practical reward —is the most productive approach in the long run. Practical applications of basic knowledge will suggest themselves.

For the most part, the remaining nutritional problems require further research and intensive education. Enrichment should certainly be continued and, along some lines, extended. A relaxation of that effort permits a relapse of nutritional status, with a high probability of increasing deficiency disease. It would also undermine our nutritional foundation, the bulwark of cheap staple foods—bread, flour, milk, salt, margarine, and so forth—upon which the nation's health would depend in an economic or other calamity. The National Research Council has described enrichment as "low-cost insurance against certain nutritional ills."

Nutritionists and allied workers in the United States appreciate the importance of developing their programs in full recognition of world nutritional needs. Today, serious world problems critically involve us all—problems that often reflect the ratio of food supply to population. Established techniques intensively applied can often remedy the local shortage of a vitamin—as shown recently in the Philippines, where rice enrichment and other measures reduced beriberi deaths in an experimental zone by 90 per cent or more. The successful use of enriched rice in the Philippines would be a major public health advance for that country.

I have mentioned problems that could be effectively attacked through extended enrichment measures, and others that require further research. This brings me to a point that should be strongly emphasized. Enrichment is a powerful weapon against malnutrition, but it must not become, either in your country or mine, the sole or final effort. Nutrition research must be intensified; and sound programs of nutrition education—the essential link between professional knowledge

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Enrichment

(Concluded from page 106)

and the improvement of a nation's food practices—must be vigorously pursued.

These are aspects of the public health program in nutrition to which industry and government can contribute, as they have done notably in the past. Let me stress the necessity of co-operation between industry and government in this movement. It has been our experience that businessmen are deeply interested in the nation's health, that they recognize its great importance, and that they want to be helpful and to do the right thing. They also have their feet on the ground and properly act only when strongly convinced. Such co-operation is highly productive in the field of education. Here, industry can bring to bear effective techniques and attractive media, which government agencies cannot obtain. Whenever government and industry participate in a sound program of nutrition education, as they have done in the United States, material progress in public health can be expected.

Nutrition education, as its main objective, should seek to establish public demand for an adequate diet, taking into account a wide range of consumer incomes. The physican, health officer, nurse, teacher, and other key persons in the community, must be prepared to guide individuals and institutions in selecting the right foods; and for this, they must be skilled in the practicalities of feeding —food values relative to cost. In commercial advertising, a greater effort should be made to show the proper relation of the promoted product to good nutrition as a whole. Finally, community leaders, advertisers, nutritionists, and others in the role of educator, should focus primarily upon the housewife, who selects and prepares the meals and guides in the formation of food habits.

The modern attack upon malnutrition should be spearheaded by enrichment, backed by education, and controlled by research. Sound food habits must always be the major objective. It is unlikely that enrichment will ever be entirely superseded by informed food selection, since food values vary seasonally and geographically, and selection to some extent is economically determined. Food enrichment has been applied on an ever-wider scale. The inauguration of the Canadian program, which offers every hope of success, is a further indication of the increasing role of enrichment in the health and strength of nations.

Civil Defence Centre for Edmonton

The federal and Alberta governments have agreed on an allocation of costs for the construction of a civil defence control centre in Edmonton. Total cost of the project, which comes under terms of the federal undertaking to share civil defence costs with the provinces, will be $83,500, toward which the federal government will contribute $30,000 during the 1952-53 fiscal year.

It is estimated that almost three-quarters of the construction work is now completed, at a cost of $60,000. The control centre, to be of reinforced concrete, is located on city suburban lots, which have been donated by the City of Edmonton.

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With the Auxiliaries

(Concluded from page 68)

with prizes donated by local merchants, a formal dance, the Charity Ball; and the sale of several hundred Christmas cards, which were made by the silk screen process by members of the auxiliary. A tuck shop is also operated at the hospital for the benefit of patients and visitors.

* * * *

Auxiliary to the Rescue

A special turning frame fracture bed was needed at the Grace Hospital Windsor, Ont., and the evening group of the ladies auxiliary came to the rescue. This newly-formed group had set aside some money, which had been raised from dues and white elephant sales, to meet a possible emergency. The fracture bed was the first gift made by the group to the hospital.

* * * *

Auxiliary to Furnish Sunroom

A bank balance of $185 has been reported by the women's auxiliary to the Provost Municipal Hospital, Provost, Alta. The main project being undertaken currently by the auxiliary is providing furnishings for the hospital's sunroom.

* * * *

Electrocardiograph Machine Gift of Hospital Auxiliary

An electrocardiograph machine was presented to the Alexandra Hospital, Ingersoll, Ont., by the women's auxiliary as their special project for the past year. The machine will be of great value to the hospital and doctors of the district who will no longer have to send patients needing this type of examination to London or Woodstock.

* * * *

New Auxiliary at Westview, B.C.

A new auxiliary has been formed at Westview, B.C., which will serve the Powell River General Hospital. The group now has 40 members.

Many Skills and Trades

One great fascination of a hospital is that it represents in one enterprise the accumulation of many skills and trades. In fact, certain of its activities represent many trades, skills, and segments of highly organized and profitable businesses outside of the hospital. The professional groups in a hospital — doctors, nurses, dietitians, medical social workers, and the technicians in the various laboratories — are familiar to all. But is consideration ever given to the fact that hospitals operate laundries, pharmacies, high pressure steam plants or that, in engineering departments, many skilled craftsmen are to be found, *i.e.*, cabinet makers, tinsmiths, machinists, electricians, plumbers and painters. Then, too, many persons of lesser skills are being trained constantly as orderlies, aides, maids, porters, and kitchen helpers.

The challenge to those of us in hospital administration is the successful melding of the highly trained, often egotistical professional groups with the other less skilled, all of whom are vitally important members of a hospital staff. It is this family of skilled and unskilled persons working together in understanding and with a devotion to duty which makes a hospital the house where science and mercy meet. — *Madison B. Brown, M.D.*

THE CANADIAN HOSPITAL

The Canadian Hospital is published monthly by the Canadian Hospital Association as its official journal devoted to the hospital field across Canada.

The subscription rate in Canada, U.S.A., and Gt. Britain is $3.00 per year. The rate for each additional subscription to hospitals or organizations having a regular subscription (and personal subscriptions for individuals directly associated with them) is $1.50 per year. The rate to other countries is $3.50 per year. Single copies, when available, are supplied at 50c each.

SUBSCRIPTION APPLICATION

To the Canadian Hospital Association,
280 Bloor St. W., Toronto 5, Ont.

Please enter subscription to *The Canadian Hospital* for one year as indicated below.

Name .....

Hospital or organization .....

Position .....

Mailing address .....

Payment enclosed $ .....

Or, send invoice to .....

Emergency Feeding

(Concluded from page 52)

invaluable.

In the pamphlet, *Emergency Feeding in Civil Defence*, suggested lists of types of persons who are in a position to make worthwhile contribution are given. Most of these list hospital dietitians, nutritionists, and dietitians engaged in commercial or industrial feeding programs. May we suggest that provincial or local dietetic associations or groups of dietitians where no local association exists, approach the local civil defence director or the director of local civil defence welfare services and offer assistance in either planning, organization or training. These officers will be most grateful for such offers. If you are in a situation where you are the only dietitian in the vicinity, read all the information available on civil defence. Each individual must take a share of responsibility and be ready to meet any emergencies that arise. We, all, would do well to heed the warning on every civil defence bulletin: "If we do not need what we learn in civil defence we lose nothing. But if we do not learn what we need in civil defence we may lose everything".

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All materials come sparkling clean . . . easier than ever, when washed in McKemco Laundry Compound. This scientifically formulated cleaning agent gets right after dirt . . . washes all fabrics fresh and clean . . . with a minimum of time and effort.

McKemco Laundry Compound is a well buffered alkali with a high pH. It prevents scale formations in your washing machines, preserves the tensile strength of material . . . and actually saves soap !

Put McKemco Laundry Compound to work in your plant NOW ! And see how efficient and economical a laundry soap can be !

Ontario Sales Representatives for Troy Laundry and Dry Cleaning Machinery. Call on us for complete repair and maintenance service or when buying new equipment.

Labor-saving Troy satin-finish, stainless washers are performing efficiently and economically in many modern laundries.

11 years of service to Canadian Industry.

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MANUFACTURERS AND DISTRIBUTORS OF SPECIALIZED CLEANERS AND ALKALIES

Compulsion vs. Free Choice

With regard to the matter of health and health services, it is wise to keep such choices close to the people affected through private insurance, Blue Cross, Blue Shield, et cetera. The proponents of compulsion feel that an inadequate amount of economic goods and services is directed into health and medical channels and, therefore, government should step in and compel an increase.

One of the objectionable features of this approach is that it denies to the individual the right to make decisions as to how his income should be allocated — food, medical service, et cetera —and, therefore, takes away from him a desirable opportunity to pass upon the worthwhileness of various elements of health and medical services.

The public has shown a willingness to pay an increasing amount for hospital care but a point can be reached where the cost of hospital care exceeds what they are willing to pay, and, consequently, might prefer to spend any excess amount in some other way; for example, some form of home care. Then, also, beyond a certain indefinite point, the expenditure of further funds for medical care might yield little or no additional net return either of an economic sort or in the form of greater satisfaction to the individual.

We can "afford" adequate health services. But it is a difficult decision to make as to what volume of services is desirable from the economic, social, and individual viewpoints. The various factors affecting health are complex and have not been blueprinted. For example, there are many uncertainties as to the relation of food and housing to health, and it is questionable whether an improvement in the area of nutrition is not at least as important as improvement in medical services as such. Similarly, in the field of medical services themselves, the situation is far from stabilized and no one possesses the wisdom for determining what types of services, procedures, techniques, et cetera, need to be expanded and which, if any, diminished.

And to go a step further, who is prepared to show that consumer expenditures on a TV set or an automobile may not help to produce human satisfaction, contentment, and even better mental health?

Indeed, here we are dealing with the very foundations of our civilization and culture. We are dealing with values — the problem of values in a free society.—*Emerson P. Schmidt, Ph.D.*

The New Day

To awaken each morning with a smile brightening my face; to greet the day with reverence for the opportunities it contains; to approach my work with a clean mind; to hold even before me, even in the doing of little things, the Ultimate Purpose toward which I am working; to meet men and women with laughter on my lips and love in my heart; to be gentle, kind, and courteous through all the hours; to approach the night with weariness that ever woos sleep and the joy that comes from work well done—that is how I desire to waste wisely my days. —*Thomas Dreier*

Let us be of good cheer, remembering that the misfortunes hardest to bear are those which never happen.—*James Russell Lowell*

Presidential Address

(Concluded from page 34)

gard to the composition of the Board of Directors. It is true that the nominating committee have endeavoured to give equitable representation on the Board to all groups and interests, but this is a well nigh hopeless task in a country of the size and diversity of interests we find in Canada. There is nothing in the constitution to determine the composition of the Board of Directors other than the will of the delegates. Secondly, the Council has no financial autonomy. It is dependent solely on the whim, or, let us say, on the good will of its constituent associations. This financial support is in the form of purely *ex gratia* contributions which may be given, altered, or withheld entirely at the will of the donors. Moreover, there is no universal yardstick or standard by which the size of these contributions are determined. In short, your national hospital association is in the position of a mendicant, forced to go yearly, hat in hand, to the member associations to beg for sustenance. I ask you, is this consistent with the dignity of a national association? Is it not an absurdity? Can you conceive of an organization so constituted continuing to function efficiently?

It has seemed to me for some years past that a re-examination of the basic principles on which the Council is founded is long past due.

In this connection I would like to pose a few fundamental questions for your consideration.

1. Do we need a national hospital association in this country? Personally, I do not see how we could do without one, but I could be wrong.

2. If the hospitals of this country need a national association to serve their interests, must not the hospitals of this country make up their minds they will have to pay for it?

3. Should a nationai association not serve the interests of every hospital, and, if so, should not every hospital contribute to its support on a strictly equitable basis? This means comparable support of the Council from a hospital in Corner Brook, Nfld., and one in Pilot Mound, Manitoba. This does necessarily mean that each hospital would deal directly with the national association. I firmly believe that the best and most effective control of the national association is through the provincial divisions; but the provincial divisions must not be in a position to determine arbitrarily just how much support they will accord the national association.

I am going to propose:

1. That each provincial association become a division of the national association, entitled by constitutional provision to specified representation on the Assembly and on the executive board of the national association.

2. That each hospital in Canada be expected and encouraged to hold membership in both the national and provincial association.

3. That the annual budget of the national association be distributed equally over all the hospitals of Canada on a bed basis or other equitable arrangement and that each provincial division be notified of the assessment of the national association on each of its member hospitals. Whereupon it shall bill each of its members for the national assessment along with whatever assessment the provincial division may require for its own local activities.

4. Monies collected by the provincial divisions on behalf of the national

association shall be remitted to the Treasurer of the national association.

5. Billing of individual hospitals shall be on such basis as will indicate to the hospital the proportionate share of their annual dues which enure to the national and provincial associations respectively.

I would like you to think over these suggestions carefully, having in mind the future existence of a national association. It is obvious that their implementation will require very extensive constitutional revision.

In order that the situation may be given very careful consideration across Canada, I would ask that you request the resolutions committee to frame an appropriate resolution instructing the incoming Board of Directors to establish a committee on revision of the constitution, thoroughly representative of all the membership, which shall consult with each of the provincial associations and be prepared to present a report dealing with these proposed constitutional revisions along with necessary amendments or re-writing of the constitution, in proper form for definite action at the next biennial meeting.

I would further suggest that the Catholic conferences should receive representation on the board of directors through the Catholic Hospital Council of Canada—a body to which they all belong.

In conclusion may I express my gratitude to all my associates on the Board of Directors for their self-sacrificing work on behalf of the Council and to bespeak for my successor the continuing support of every hospital, large and small, in this country, to the end that the Council may continue to function as an indispensible necessity in the day-to-day operation of Canadian hospitals.

What We Are

It is not by regretting what is irreparable that true work is to be done but by making the best of what we are. It is not by complaining that we have not the right tools, but by using the tools we have. What we are, and where we are, is God's providential arrangement—God's doing, though it may be man's misdoing; and the manly and the wise way is to look your disadvantages in the face and see what can be made of them.—*Frederick W. Robertson*

Dishwashing Techniques

(Continued from page 58)

compartment is drained. In establishments where steam is available, steam coils have been used in place of the immersion element. The steam coil, however, does not provide the automatic control of temperature achieved by the thermostatically controlled electric element and so its general use has been discouraged. Steam coils have proved most effective in hospital ward kitchens where speed is not an essential factor and the water can be raised to the boiling point before the dishes are removed.

Experience has shown that the system can be operated most successfully by using three baskets and a two-compartment sink. The dishes are washed by hand in the first compartment, racked in the basket, and immersed in hot water in the second compartment. By the time the third basket has been filled with washed dishes, the dishes in the first basket are dry and ready to be racked and the dishes in the second basket are sanitized so that the basket can be moved on to the drainboard to allow these dishes to dry. This operation eliminates the necessity for towel-drying the utensils and, if the procedure is properly carried out, the dishwasher's task is made easier and properly sanitized dishes are produced. In following this technique the dishes normally remain in the sanitizing compartment for a period of three to six minutes, as this is the time required to rack the dry dishes, scrape, prepare, and wash another basketful.

Coincident with the experiments in heat sanitizing, a survey of dishwashing efficiency was undertaken. The following comparisons between premises using chemical sanitizing and those using heat sanitizing is drawn from the results obtained in this survey. At the time of the survey only seven establishments were using the equipment shown in the diagram and, against these, we have matched seven establishments selected at random from the files. Only premises where chemical sanitizing appeared to be in use at the time of inspection have been used.

Laboratory Findings†

	Chemical	Heat
Utensils involved	95	96
Average count per utensil	147*	21
No. of utensils producing counts above standard of 100 colonies	40	4
No. of utensils producing counts below 50 colonies	44	88
Highest count per utensil	1600*	120

While this comparative table does not involve enough establishments or utensils to produce conclusive evidence, it does indicate that the desired results can be more frequently obtained by the use of heat sanitizing. The elimination of towel drying has been welcomed by those involved in handling the utensils. The cost of operating compares favourably with the cost of chemical sanitizing and a marked reduction in cost of laundry for towels has been found. In discussion with persons operating the equipment, it has been established that they do not experience undue fatigue in lifting baskets made to fit compartments built to the specifications shown in the diagram. If the installation of

**Excluding eight utensils which produced plates listed as too numerous to count.*

†Royal Jubilee Hospital Laboratory, Victoria, B.C.—Dr. R. G. D. McNeely, Director. Method: Standard method of swab testing utensils using 4 utensils average and physiological saline solution with sterile swabs for collecting specimens.

larger sinks is contemplated, care must be taken to ensure they will not be so large that a basket full of dishes will be too heavy for constant lifting.

The equipment shown in the diagram can be installed for little more than the cost of a three-compartment sink of comparable size. In our opinion, satisfactory results can be obtained by the use of this simple operating technique which allows little scope for human error.

Canadian Cancer Society
Industrial Education Program

The Canadian Cancer Society has appointed a National Industrial Education Committee, under the chairmanship of Carl. B. French of Toronto, Ont., to co-ordinate and assist the provincial divisions of the Society in an educational program directed to industrial, office, and store employees.

In a recent report to the Society, Mr. French quoted the Society's president, F. G. Butterfield of Regina, on the need for an industrial education program. He said: "There seems to be no doubt about the need for taking our education program to employed groups during the hours of their employment. Since they work in office, factory, or store, all day, their off-duty hours are spent in relaxation and few come in contact with our normal educational channels."

It was stated that where industrial education work in the field of cancer was already being undertaken in Canada via pamphlets, films, talks, and other means the reception from both management and employees has been most enthusiastic.

Nursing Instructors, B.C. Civil Service,

School of Psychiatric Nursing.

Salary: $239 rising to $266 per month. Qualifications: Eligible for registration in B.C. and have certificate in teaching and supervision; preferably post-graduate study (or its equivalent) and experience in psychiatric nursing. Candidates must be British subjects, under 40 years, except in the case of ex-service women who are given preference. Further information and application forms may be obtained from the Director of Nursing, Provincial Mental Hospital. Essondale, or the B.C. Civil Service Commission, 636 Burrard Street, Vancouver, B.C.

Purchasing Agent Required

For the new St. Thomas-Elgin General Hospital, St. Thomas, Ont., applications will be received in writing for the position of Purchasing Agent, preferably one with experience in the hospital field.

Apply in writing, stating qualifications and salary expected, to Mr. J. D. Adams, Secretary, St. Thomas-Elgin General Hospital, St. Thomas, Ont.

Superintendent of Nurses Required by Hamilton General Hospital

The Hamilton General Hospital invites immediate enquiries for the position of Superintendent of Nurses. Applicants are requested to state qualifications and experience.

Address applications to the Chairman, Board of Governors, Hamilton General Hospital, Hamilton, Ontario.

Administrator Desires Position

Administrator, age 36 years, with 20 years successful experience in every type of hospital, including complete charge of large general hospital, seeks post in progressive public or private hospital or clinic giving scope and reward for application of efficient hospital methods, initiative, creative ability and hard work. Box No. 634W, The Canadian Hospital, 57 Bloor St. West, Toronto, Ont.

Dietitian Wanted

Dietitian required for 125 bed hospital. New hospital to be opened this summer. Apply to Superintendent, Charlotte County Hospital, St. Stephen, N.B.

Wanted—Records Librarian

Registered Medical Records Librarian for 245-bed General Hospital. Pleasant working conditions, new hospital. Duties to commence at once. Please write to: Superintendent, Sudbury General Hospital, Ramsay Lake Road, Sudbury, Ontario.

Nursing Supervisor Wanted

For Queen Elizabeth Hospital, Toronto, a nursing supervisor who is interested in general administration and management of hospitals. 500-bed institution. Apply to the Superintendent.

Administrator Available

Intending British emigrant, experienced in hospital administration and supplies purchasing, desires similar position in Canadian hospital. Box 676T, The Canadian Hospital, 57 Bloor Street West, Toronto 5.

Sales Representative Wanted

FIRST CLASS OPPORTUNITY for full-time representative, experienced in sale to hospitals of surgical and electro-medical equipment, instruments, sterilizing plant, and operation tables, offered by long established British company solely occupied in the manufacture of such equipment. Success will result in establishment of Canadian Branch of parent Company. Applicants will be interviewed in Canada soon. Write stating age, experience and salary required. Box 627G, The Canadian Hospital, 57 Bloor Street, Toronto 5, Ont.

Dietitian Required

Dietitian for new 130-bed hospital and 40-bed residence. All new equipment. Two cafeterias. Bilingual person with very good organizing ability is preferable. Located central, Montreal. New kitchen to operate October 1, 1953. Should be available August 1, 1953. Box 639R, The Canadian Hospital, 57 Bloor St. W., Toronto.

Dietitian Wanted

Graduate Dietitian, for 200 bed hospital, wanted immediately. Further particulars apply to Sister Superior, Superintendent, Providence Hospital, Moose Jaw, Sask.

Laboratory Technician Wanted

Laboratory technician for a 74 bed general hospital. Apply stating qualifications and salary expected to, Superintendent, Portage la Prairie General Hospital, Portage la Prairie, Manitoba.

Educating the Lay Reader

For the second year the lay magazine reader will have directed to his attention a series of advertisements, published in Newsweek, dealing with x-ray diagnosis and treatment. The advertisements are part of the advertising and public relations programs of General Electric X-Ray Corporation.

The first six advertisements tell dramatically how x-ray, in the hands of trained medical men, means new hope for the injured and ailing. More than that, each explains away some of its mystery. One, for example, headlined "An itch put him on the shelf," was written at the suggestion of a prominent dermatologist to dispell the idea that x-radiation is used only to treat cancerous conditions.

Although Newsweek will carry these messages to more than 850,000 serious readers, many of them leaders in their communities, additional thousands can be reached at a psychological moment if copies of this brochure were placed on reception room tables in physicians' offices and in hospitals.

Copies of a reprint brochure are available without cost by addressing requests to W. R. Petrie, Manager Advertising and Sales Promotion, General Electric Company, Milwaukee 1, Wisconsin.

* * *

New Bed Lift Is Trouble-Free

The De Puy Improved Bed Lift eliminates heavy lifting when the head or foot of a bed needs to be raised. The De Puy improved bed lift works on a mechanical principle. Precision gears and a free turning handle make it easy for even the most slender nurse to raise a bed with a heavy patient. The jack is on swivel rollers that roll wherever needed. Once the bed is raised it may be put on blocks and the lift used elsewhere. Or, just leave the jack in place until elevation is no longer needed. For complete information and prices write De Puy Manufacturing Co., Warsaw, Indiana.

* * *

Dri-Heat Hot Plates Keep Food Hot

Food may be served piping hot direct to the patient in all parts of the hospital from one central kitchen with the new Dri-Heat Hot Plates. A heat retaining element, which can be heated in a matter of minutes on a range or in an oven, is inserted in a stainless steel container. The plate with the patient's dinner on it is then placed over it and a stainless steel cover put on top. The food is now ready to be served and will keep hot for a considerable length of time. When a large number of Dri-Heat hot plates are being used, a specially designed Electric Dri-Heat element dispenser can be installed to heat the retaining elements. Further information may be obtained from the Canadian distributors, R. G. Venn & Company, Toronto.

* * *

"Chloropads" for Hospital Beds

The General Cellulose Company, Inc., Garwood, New Jersey, well known for their disposable protective bed pads, in both standard and special sizes, have announced a new and significant contribution in the improvement of hospital patient care and comfort.

Development of "Chloropads", impregnated with a special Airkem formula containing chlorophyllins for added freshness and a potent quaternary amonium bactericide to inhibit the growth of odor forming bacteria, make this new product the first and only bed pad of its kind on the market, according to the makers.

Following months of collaboration between The General Cellulose Company and Airkem, Inc., the present "Chloropad" was perfected with the formula containing chlorophyllins without the disturbance of the absorptive qualities and binding elements of the pads.

* * *

Insect Control Folder Published by West

The control of industrial and institutional insect infestations is the subject of an eight page illustrated folder just published by West Disinfecting Co., Long Island City, N.Y.

West, well known in the industrial sanitation, maintenance, and insect control fields recommends a three step program for economical control of insects: Use of proper atomizing and/or spraying equiment; use of proper insecticide formulated specifically for type of job to be done; proper survey and analysis of requirements together with a tailor-made program for insect control in individual plants.

The folder discusses types of equipment, installations, and minimum quantities of insecticide needed to rid various sized areas of flying and crawling insects. West's specially designed fogging and spraying equipment, and the different West insecticides and fumigants are described in some detail.

* * *

New Merck Product Now Available

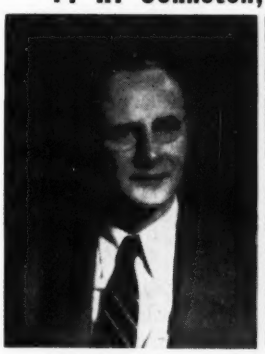
The availability of Dental Ointment of Hydrocortone Acetate for the treatment of certain types of acute or chronic inflamation of the gums has been announced by Merck & Co. Limited, manufacturing chemists. The new form of Hydrocortone Acetate, the Merck brand of hydrocortisone acetate, will be made available through wholesale distributors to hospitals and pharmacies in collapsible 5 gm. tubes, each gram of ointment containing 25 mg. of Hydrocortone Acetate. The product will be available on prescription only.

Dental Ointment of Hydrocortone Acetate is used as an aid in the treatment of various diseases occuring around the teeth, including acute or

(Concluded on page 124)

CANADIAN HOFFMAN NAMES

F. H. Johnston, Executive Vice-President of Canadian Hoffman Co.



Frank H. Johnston

Douglas Campbell

Albert M. Mejia

L. G. Austin

Frank H. Johnston has been named executive vice-president and director of the Canadian Hoffman Machinery Company Ltd. Mr. Johnston's appointment was announced by Albert C. Bruce, chairman of the Board of Directors of Canadian Hoffman, leading manufacturer of dry cleaning and laundry equipment, garment pressing machines and industrial cleaning and filtration products. Mr. Bruce said that the new executive vice-president will also serve as the firm's general manager.

Mr. Johnston is a veteran of fifteen years of service with Canadian Hoffman. Through most of these years he has served as the company's assistant treasurer, a post he will continue to occupy along with his new duties.

Douglas Campbell and Albert M. Mejia were each named vice-president and director, and Mr. Campbell was also appointed works manager of the firm's Newmarket plant.

In addition, L. G. Austin has been named director and appointed sales manager to succeed J. I. McKeown, now stationed in California by the U.S. Hoffman Machinery Corporation.

Mr. Campbell served with the Royal Canadian Air Force during the war. Like Mr. Johnston, he has been with Canadian Hoffman fifteen years and until his promotion he was factory superintendent at Newmarket.

Mr. Austin joined the Canadian Hoffman organization in 1952. He has been associated with the dry cleaning and laundry machinery and supply industry throughout Canada for twelve years.

Across the Desk

(Concluded from page 122)

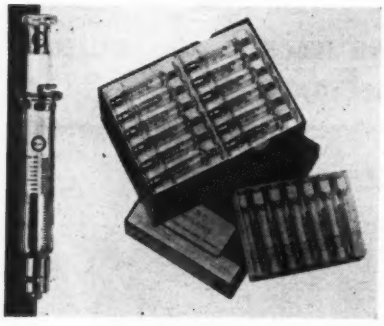
chronic gingivitis, hyperplastic gingivitis, and chronic desquamative gingivitis, to facilitate the restoration of tissue tone.

It was discovered that following direct application of Hydrocortone Acetate, the gum tissue becomes firm and tends to return to its normal colour and tone and that bleeding of the gums does not occur even while solid food is being chewed. For local treatment only a small concentration of the hormone is necessary to produce the desired relief.

* * * *

Becton Dickinson Develops Interchangeable Syringe

Becton, Dickinson and Company, Rutherford, N. J., has anounced the introduction of "B-D Multifit", a new syringe with interchangeable parts and clear glass barrel that makes possible substantial savings and meets a long-standing need of hospitals.



To determine with maximum reliability the economics gained by the use of the B-D Multifit syringe, highly tests were conducted for two years in large metropolitan hospitals. More extensive tests followed throughout the country.

Hospital administrators reported in every case exceptional savings in equipment and time. Replacement costs following breakage were lowered and handling time was cut by high speed reassembly of parts. Hospital staffs will be able quickly to reassemble, replace and clean the instrument parts.

The first Multifit size introduced is two cc. Later the company plans to introduce additional sizes.

Multifit syringes apply the Becton, Dickinson principle of unground, moulded clear glass barrels to preserve the protective "skin" of the glass and thus to ensure maximum service.

New Instrument Speeds Up Tests of Blood Donors

An electronic temperature-taking instrument, twice as accurate as a doctor's thermomenter and up to 60 times as fast, was demonstrated recently in Philadelphia for the first time during a Red Cross Blood donor visit.

The new decide, called a "Thermotron," was specially adapted by engineers from Minneapolis-Honeywell's Industrial Division as an experiment in speeding up the time-consuming temperature-taking phase of blood donor examinations. The time gained is an important factor, particularly in visits to large industrial plants or in times of disaster when it is necessary to process rapidly hundreds of donors.

During the demonstration the instrument registered the donor's temperature in less than 4½ seconds. Although this is the first application of the instrument to measure body temperatures, the Honeywell engineers explained that it is widely used in industry. It is capable of measuring temperatures as low as—400°F. and is believed to be the only industrial instrument capable of measuring temperatures as high as 7,000°F.

* * * *

Penfield Water Demineralizer

Readers will be interested in the availability of the new Penfield M-100 Mono-Column Demineralizer. This demineralizer operates on the extremely efficient and economical mono-column method: cation and exceptionally strong anion exchangers intimately mixed in a single unit tank through which the raw water is passed only once.

Once a Penfield M-100 Demineralizer is set in operation, up to 90 GPH of super high purity water is produced completely automatically—without he use of heat or steam power. Regeneration of the resins is accomplished (as required) in a single operation consuming under an hour of time by means of a uniquely simple re-generation system that is an integral part of the unit.

Copies of a new Penfield Model M-100 catalogue sheet may be obtained by writing to J. W. Anderson Co. Limited, Box 455, Hamilton, Ont.

* * * *

De-Fly-er Automatic Insect Killer

De-Fly-er of Canada announces that their completely new unit is now manufactured in Canada. De-Fly-er is the modern, scientific way to kill flies, moths, mosquitoes and other exposed insect pests such as spiders, ants and cockroaches.

The unit consists of an attractive, metal wall frame, bowl containing special element and De-Fly-er crystals, and electric cord. It costs less than 6c a day to operate, each unit protects up to 15,000 cubic feet, and requires refilling only every 30 days.

Entirely automatic, it is odourless, noiseless, invisible and tasteless. It has absolutely no adverse effects on animals or humans, it is claimed.

Plugged in to any electric outlet, the released vapor kills insects on contact. There is a lifetime guarantee on every unit. Over a quarter of a million units are now being used in establishments where insects are a nuisance or menace to health. Direct enquiries to — De-Fly-er of Canada, 2013 Avenue Road, Toronto, 9.

* * * *

Gift-Pax Comes to Canada

Gift-Pax, the merchandise sampling service for new mothers at their bedside in the hospital, and which now has a nationwide coverage in the United States, will go international on July 1st with the extension of its service into Canada. The initial coverage will include the metropolitan areas of Toronto, Quebec, and Montreal, after which it will be expanded to the entire provinces of Ontario and Quebec and to Vancouver, B.C. at an early date.

The addition of the Canadian territory on July 1st will increase the distribution by 5,000 packages a month, presented to mothers in 100 hospitals. Gift-Pax will establish a franchise office in Toronto.

The Gift-Pax service is available to manufacturers of products for the baby, and of cosmetics and good grooming aids for the mother.

Index of Advertisers

JUNE, 1953

Authorized as Second Class Mail, Post Office Department, Ottawa. The Canadian Hospital is published monthly by The Canadian Hospital Association, 57 Bloor Street West, Toronto 5.

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Made from finest materials available!

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PATIENTS' APPAREL

You actually save money when you invest in Corbett-Cowley **Wrappers, Bathrobes and Dressing Gowns!** That's because quality is built into every garment . . . quality that shows itself in the number of times they can be washed yet still retain their attractive patterns and colors . . . in the way in which they stand up to hard and continuous wear! Furthermore, Corbett-Cowley allows in each garment a predetermined margin for shrinkage . . . ensuring patients a warm and comfortable fit—regardless of how many times the garment has been laundered! Made in assorted patterns from washable eiderdowns, full cut, and available in sizes Small, Medium, and Large. Immediate delivery on all orders.

CORBETT-COWLEY

PATIENTS' WASHABLE WARD SLIPPERS

Made to be laundered, sterilized and mangled. Triple soles, double sides, well reinforced throughout. Sizes Small, Medium, and Large. Price $13.20 per dozen pairs.

CORBETT-COWLEY
Limited

2738 Dundas St. W., Toronto, 9 424 St. Helene St., Montreal 1

SALES TAX will be added to billing unless orders are accompanied by Regulation Sales Tax Exemption Certificate.

Index of Advertisers

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CORBETT-COWLEY

PATIENTS' APPAREL

You actually save money when you invest in Corbett-Cowley **Wrappers, Bathrobes and Dressing Gowns!** That's because quality is built into every garment . . . quality that shows itself in the number of times they can be washed yet still retain their attractive patterns and colors . . . in the way in which they stand up to hard and continuous wear! Furthermore, Corbett-Cowley allows in each garment a predetermined margin for shrinkage . . . ensuring patients a warm and comfortable fit—regardless of how many times the garment has been laundered! Made in assorted patterns from washable eiderdowns, full cut, and available in sizes Small, Medium, and Large. Immediate delivery on all orders.

CORBETT-COWLEY

PATIENTS' WASHABLE WARD SLIPPERS

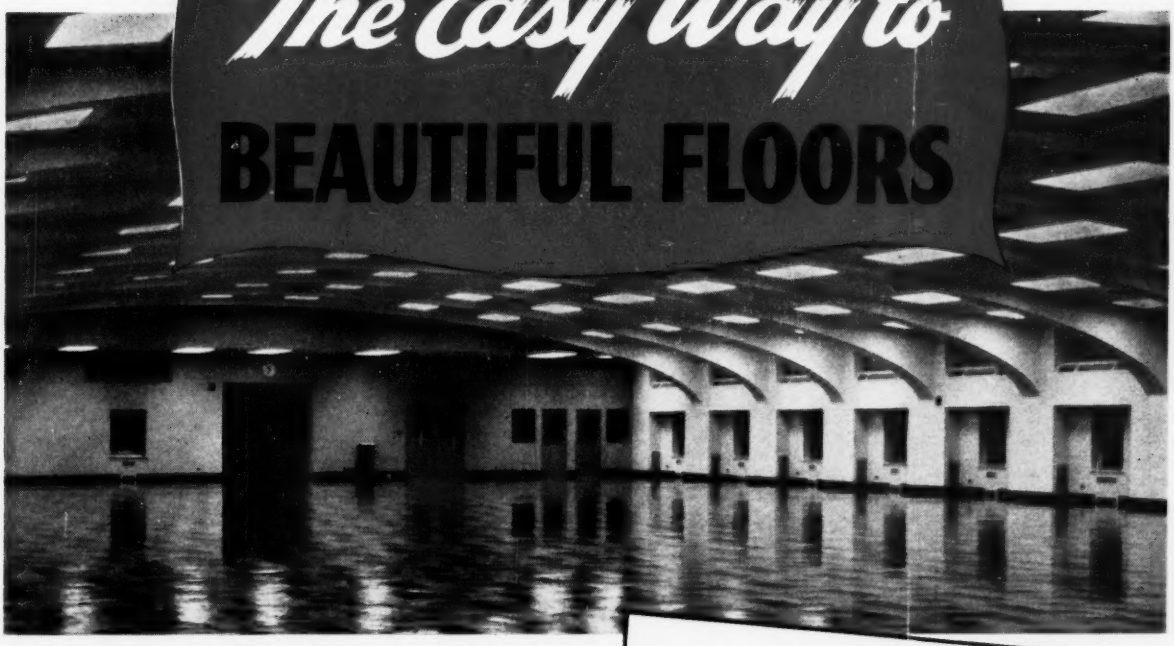
Made to be laundered, sterilized and mangled. Triple soles, double sides, well reinforced throughout. Sizes Small, Medium, and Large. Price $13.20 per dozen pairs.

CORBETT-COWLEY *Limited*

2738 Dundas St. W., Toronto, 9 424 St. Helene St., Montreal 1

SALES TAX will be added to billing unless orders are accompanied by Regulation Sales Tax Exemption Certificate.

The Easy Way to BEAUTIFUL FLOORS



CROMAX

Liquid Floor Wax

Give your floors a gleaming protective finish that is hard, durable and non-slip, with CROMAX Liquid Floor Wax. Your beautiful floors will stay beautiful.

CROMAX is a water emulsion wax made from pure Carnauba Wax. It is non-flammable . . . economical . . . and easy to use. Contains no solvents or fillers of any kind. CROMAX is especially prepared for the treatment of Rubber, Linoleum and Mastic Tile floors.

CROMAX is excellent for use in offices . . . schools . . . hospitals . . . hotels . . . apartments . . . and wherever heavy traffic occurs.

INDUSTRIAL LIFE INSURANCE COMPANY
HEAD OFFICE
QUEBEC

March 28, 1951.

G.H. Wood & Company Ltd.,
Quebec City District Branch,
Quebec, Que.

Dear Sirs:

The floors in our new head office building are entirely covered with rubber tile and we were quite anxious to have this large area properly treated.

In this connection we used your "Cromax" as a floor wax. The results were completely satisfactory - the finish is hard and lustrous and emphasizes the beauty of the colouring and design in the floor.

"Cromax" apparently has excellent "non-slip" qualities - this, of course, is very important.

Your representatives gave us excellent service which we did appreciate.

Yours very truly,

J. E. Brack

SEB/NC

TORONTO
MONTREAL
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Wood's SANITATION FOR THE NATION

BRANCHES
THROUGHOUT
CANADA

G. H. WOOD & COMPANY LIMITED